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The West Virginia MEDICAL JOURNAL

Published by The West Virginia State Medical Association

The human soul on fire is man's greatest weapon.—
Marshal Foch.

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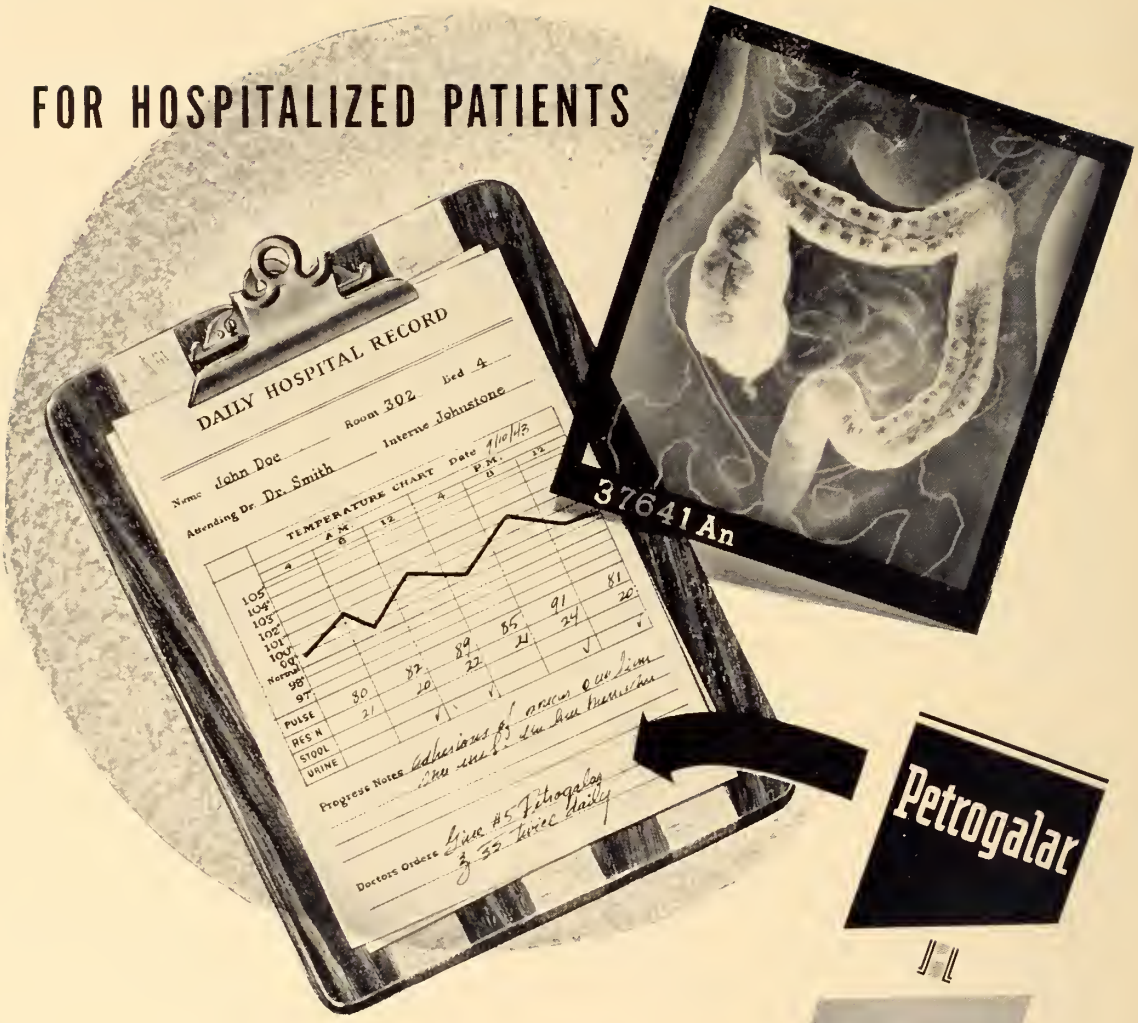

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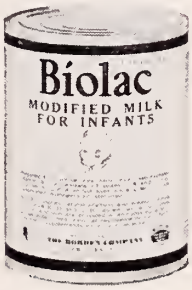

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PERIPHERAL VASCULAR DISEASE AND INDUSTRY*

By A. WILBUR DURYEE, M. D.
New York, N. Y.

In this era of medicine, with cardiovascular disease heading our mortality lists and with the peripheral manifestations so frequently a cause of disability, it behooves us to take time to consider this problem from the aspect of industry. Are the physicians employed by industry being trained in the recognition of the diseases affecting the peripheral vascular system? Do they understand the principles of therapy in treating the injured whose problem is complicated by abnormal blood or lymphatic supply? Are they on the lookout for possible vascular complications of industrial accidents?

I shall attempt to give as concisely as possible a summary of these three aspects of this field of medicine. In the first place, every worker in industry is a potential sufferer from some peripheral vascular disease. Such disease may be present when he is hired and may either render him inefficient in his work or incapacitate him when the effort of his occupation aggravates the pathological condition.

THE AUTHOR

Dr. Duryee, graduate College of Physicians and Surgeons, Columbia University, New York; Postgraduate Medical School and Hospital; Associate Clinical Professor of Medicine, New York Postgraduate Medical School and Hospital, Columbia University; American Health Association; American Therapeutic Society.

Although free from evidence of vascular disease when first employed, many workers may later contract such disease unrelated to their occupation. Immediately, the industrial physician must determine whether or not the disease is related to the employee's work. Very often it is the family physician and not the industrial physician who recognizes the disease. Regardless of who makes the diagnosis, careful handling of the problem often prevents unnecessary medicolegal complications which work a hardship on the employer and employee alike. If, at the earliest recognition of such a process, the employee is convinced of its relation or nonrelation to his occupation, the entire management of his problem will be much easier. In order to

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accomplish this, the physician must be able to diagnose the disease and to distinguish between peripheral vascular disease—related to, unrelated to or aggravated by, industrial hazards or accidents.

In order to visualize the possible underlying peripheral vascular diseases from which the employee may suffer, let us review a list[1] of arterial, capillary, venous and lymphatic problems.

Such a list is rather startling to the physician who has not focused his attention on this field of medicine, but let me point out that many of these pathological processes are rather rare. Moreover, if we approach the problem, not from the viewpoint of nomenclature but from an intelligent physiological viewpoint, we shall accomplish much more.

Let us, therefore, consider vascular diseases impairing arterial supply, regardless of name. A few questions asked of the patient will often lead one to a diagnosis or to a suspicion of poor arterial function. The patient may have one extremity colder than another, or it may be that all extremities get excessively cold on ordinary exposure or emotion. Cuts and injuries heal slowly. Typical intermittent claudication occurs after set distances of walking. Night pains in the legs or arms awaken the patient. The fingers or hands go to sleep or tingle.

Then comes the physical examination—all too frequently done with the patient supine or standing and stripped only to the waist. Observation of the entirely nude patient will readily bring to light trophic changes in an extremity, ulcers, abnormal pulsations such as those found accompanying aneurysms or arteriovenous anastomoses, pallor on elevation of the extremity above the heart level, and excess rubor on dependency. Palpation will reveal normal or abnormal pulses or pulsations, the relative temperature of the extremity, and will give subjective evidence of tenderness. Elevation of the hands over the head will frequently obliterate the pulses in a patient with a scalenus anticus syndrome and auscultation will reveal bruits.

All of the above clinical observations may be made in from three to five minutes and may save hours of treatment and litigation at a later date. Rarely do we have to turn to the complicated proceedings of oscillometry and vasodilatation tests, intravascular x-ray studies and circulation time tests. Ninety per cent of vascular problems should be detected by simple clinical observation.[2]

Diseases involving the veins are even more easily recognized. The history of varicosities, attacks of phlebitis, night cramps, and ulcers is usually easily obtained. Again, examination of the stripped individual in the supine and erect positions will demonstrate abnormal veins, cyanosis, eczema, edema and tender, red swollen areas associated with varicosities and with phlebitis.

Capillary disease is evidenced by the tendency of the patient to suffer hemorrhages into the skin or mucous membranes. Such hemorrhages, of course, may be due basically to a pathological condition of the blood and not of the vessels.

Lymphatic disease should be rarely overlooked as the acute processes are manifested by redness, heat and swelling, and usually by systematic febrile reaction, while the chronic condition shows permanent edema, and those cases of long standing a brawny type of edema.[3] The industrial physician should be on the lookout for the man with chronic lymphedema who applies for a position and before examination elevates his legs for a long period or wears a stocking or bandage. Such individuals often come back months later with claims of disability due to occupational disease.

The next part of this problem confronting industry deals with the question of hiring individuals who manifest peripheral vascular disease. In this day of manpower shortage, skilled workers who hobble to their jobs are employed. In prewar days, industry took only those who were fit. There is a happy medium and it should be the job of the industrial physician to guide and direct the employment of the man with vascular disease.

At this point let us consider what precautions must be taken with employees suffering from arterial impairment. First, make it imperative that they receive proper treatment[4] and arrange a time schedule so that this can be done. Too often, if the worker is not permitted to receive medical care during the working day, he is usually too fatigued by evening to report to a physician.

Second, place such employees in positions where the reduced arterial supply will be adequate for their work. A man with arteriosclerosis or thrombo-angiitis obliterans can stand behind a machine all day turning out excellent work, but he may not be able to walk long distances without pain or unless he walks slowly, with consequent loss of time. Likewise, he can be comfortable working in a room temperature of from 60 to 80° F. but if standing in front of a blast furnace, he may rapidly develop gangrene, or if working in a refrigerator he may freeze his feet.

REPORTING OF SMALL INJURIES IMPORTANT

Third, instruct these patients in the protection of their extremities, i.e., proper shoes, clean, heavy (preferably woolen) socks each day and the reporting of and immediate attention to small injuries.

Fourth, make frequent medical examinations (every four to six months) in order to watch the progress of the disease and also make them when an employee is shifted from one job to another.

Fifth, it is important to recognize special and unusual arterial impairment problems and to adjust the individual to these circumstances. One such problem is that of a scalenus anticus syndrome.[5] If such a syndrome is recognized at the time of employment, the employee must not be placed in work necessitating heavy lifting or in any job which causes the continued and strenuous use of the muscles of the shoulder girdles.

In individuals suffering from venous disease the following precautions must be taken:

1. Individuals with phlebitis of any type or in any stage, are not employable and if working, should be immediately placed under treatment and their work stopped.[6]

2. Individuals with varicose veins, uncomplicated, should be placed at occupations in which periods of long standing are not necessary and where they may be permitted to sit down and elevate the legs frequently. They should be encouraged to wear some type of support or to have the proper surgical elimination of the diseased veins.[7]

3. Individuals with varicose veins complicated by ulcer formation should wear continuous support, be given desk jobs, and if possible, a period of treatment to heal the ulcer and to remove the veins causing it.

Lymphangiitis precludes employment and a chronic lymphedema presents a problem of judgment dependent on its degree and its response to supportive treatment. Persons with mild cases of lymphedema may work at sedentary jobs with little aggravation of the process.

At this point let us consider the problem facing the physician who treats the injured employee by surgery or by the application of mechanical apparatus or casts. A careful evaluation of the blood supply to the damaged extremity is necessary before instigating such procedures. Tight casts too frequently reduce arterial supply in diseased arteries to the point of gangrene, or cause thromboses in veins, which later cause the development of thrombophlebitis or the throwing off of pulmonary emboli. The clinical observations discussed in the first part of this paper must be considered when treating any injured extremity.

THE RESULTS OF TRAUMA

I. Thrombosis.—While there is considerable disagreement concerning the formation of arterial thrombi in normal vessels, there is sufficient evidence to show that such a process may take place in crushing and tearing accidents. Small thrombotic lesions may extend centrally if arterial flow is further impaired by continued pressure of any type, such as that produced by tourniquets, casts and braces. Moreover, if the accident is severe

enough to produce shock, we have the complicating factor of reduced blood flow due to generalized vascular collapse and if such a state exists for any length of time, an ascending thrombosis may develop. If the individual has a hyperactive vasomotor system, arterial supply may be markedly reduced by vasospasm. Even the largest arteries are capable of a high degree of occlusion due to the stimulation of the sympathetic system.

Finally, an injury which traumatizes the intima over a considerable length of an artery is more apt to produce massive thrombosis as compared to an injury producing a clean cut through a vessel.

ARTERIAL RUPTURE

II. Arterial rupture or severance due to sharp instruments or tools or bits of steel is usually easily diagnosed by the type of bleeding and easily controlled by pressure, tourniquet and ligation. Many a femoral artery has been tied in the upper thigh with excellent collateral flow and a reasonably good vascular supply remaining through the collateral vessels.

III. Arterial aneurysm following trauma is not rare. If the injury has damaged one or more coats of the artery without complete rupture, the steady pressure of the blood may, in the weeks following, produce a ballooning out of the wall of the artery and the production of either a simple aneurysm or dissecting aneurysm; the former is easily detected by the palpation of a pulsating mass and the latter usually by pain and tenderness along the course of the vessel. The diagnosis of such a process is often simplified by the injection of a contrast substance into the artery proximal to the lesion and x-raying the extremity while the injection is taking place.[8] Such contrast substances are usually iodides (Diotrast 35%) or thorium salts (thorium dioxide—Thorotrast).

IV. Arteriovenous anastomoses, simple or complicated by aneurysms, are becoming more frequent. Small bits of metal frequently penetrate the adjoining walls of arteries and veins with the establishment of new vascular channels or short circuits between these vessels. Although one would expect the diagnosis of such conditions to be fairly easy we frequently see such diagnoses missed for months after the injury has healed.

The symptoms depend largely on the location of the anastomosis, its size and its duration. Small lesions may be present without symptoms forever, or for a long time. Large ones are self-evident almost immediately. The local symptoms usually consist of pain or aching in the affected limb at the site of the short circuit or distal to it. There is usually swelling of the entire extremity with cyanosis of the distal parts. There is coldness distal to the lesion; rarely, marked trophic changes or gangrene. There is often a sense of throbbing and occasionally the injured is aware of a murmur or thrill. The veins receiving the arterial blood become distended and if superficial, may be seen pulsating; when the extremity is elevated above heart level, they do not collapse.

If the anastomosis is a large one, the heart may dilate and signs of cardiac insufficiency are noted, a tachycardia persists, and often a relative mitral murmur is heard. If the pathological condition is corrected, there is a rapid return to normal cardiac function if the process is not complicated by some other form of heart disease or has not been present for too long a period. It is, therefore, apparent that in every suspected or proven arteriovenous anastomosis, an x-ray of the chest, an electrocardiogram, and careful clinical observation of cardiac function are indicated.

ARTERIOGRAMS

The diagnosis of such short circuits can be further substantiated by arteriograms. Analysis of the venous blood from the corresponding veins of two extremities should show an increased oxygen content in the veins of the involved side, provided the blood obtained is taken from veins proximal to the anastomosis.

Pathology of arteries due to injury may be functional as well as organic. Indirect trauma may cause spasm of various sized

vessels through stimulation of the vasospastic fibers of the sympathetic nervous system. We have seen local spasm in the following industrial procedures: the operation of air or steam triphammers or riveters, the operation of telephone switchboards, and the operation of drill presses, etc.

In employees active in such occupations, it seems that the repeated or vibratory type of trauma acts through the sympathetic nervous system to produce a high degree of spasm of the arterioles and smaller arteries. This may be so severe and prolonged that gangrene results. Such gangrene, however, is usually superficial and not massive.

Patients complain of coldness, tingling, numbness and sometimes burning of the extremity involved. If gangrene develops, or even pregangrenous trophic changes, the local pain may be very severe. If the right hand is involved and such individuals attempt the same work with the left, it usually shows a like process in a short time. Excessive cold or work under tension seems to precipitate such processes.

A local single severe trauma to a nerve, such as that caused by a bullet wound, may also produce a high degree of spasm of even the major arteries. This injury may involve the sympathetic supply in the adventitia of the artery. The spasm may be so marked that it would objectively appear that the main blood supply has been severed.

VENOUS

I. Varicose veins.—It is doubtful whether or not varicose veins are actually caused by occupational factors. Although it is assumed that work necessitating long periods of standing in one position is prone to produce varicosities, it has not been proven that this factor alone is adequate. Most physicians dealing with peripheral vascular diseases believe that constrictive clothing, braces, tumors, a previous phlebitis, or congenital defects are of primary etiological importance. However, there are certain occupational activities where metal or wooden objects may cause continuous pressure adequate to produce such disease. Men working on ladders with a leg hooked over a rung for long periods have been known to develop a varicose vein in that leg.

II. Thrombosis in healthy veins from pressure alone is rare. A segment of a normal vein may be ligated and the stagnant blood will remain fluid for a very long period. However, if the intima of the vein is traumatized, clotting readily takes place. Therefore, in healthy veins a real injury to the intima is usually necessary in order to produce venous thrombosis.

III. Phlebitis.—If such an injured area is infected or if infectious material drains into it from a wound, phlebitis results, either local or ascending or, in rare instances, it may become migratory. One of the difficult problems in industrial accident injuries which are followed by phlebitis is the determination of causal relationship. It is unusual for an injured person to develop clear-cut phlebitis before an elapse of from twelve to twenty-four hours following an accident, and rarely does it develop later than three or four days after an injured area is healed and free from infection. There is, however, a group of cases of low grade venous infections that often do not manifest themselves until the patient resumes activity.

IV. Varicose ulcers.—Such lesions develop only where venous drainage is inadequate. An injury, destroying tissue and at the same time starting a thrombophlebitis in the veins draining the injured area, may produce venous stasis causing chronic ulceration or slow healing.

TREATMENT

It is not within the scope of this paper to discuss the therapy of peripheral vascular disease in general. However, when the physician is confronted by emergencies of industry he should be prepared to treat those who have injuries superimposed on existing peripheral vascular disease as well as those who sustain injuries to the vascular supply itself.

In the first group of patients, minor injuries that would ordinarily respond to the simplest first aid measures often precipitate

major episodes of gangrene leading to amputation. Hastily applied tincture of iodine may start a chemical burn and the treated area may be the site of gangrene in a few days. The injection of novocaine to block the sensory nerves of a finger before removing a splinter may result in vasospasm from the adrenalin, which spasm may be sufficient to precipitate a black finger if the subject is a potential or early sufferer from thromboangiitis obliterans. Therefore, in the recognized case of peripheral vascular disease avoid necrotizing antiseptics, tourniquets, adrenalin, and excessively hot soaks. Use soap and water, nonirritating antiseptics, and keep the extremity in an environmental temperature of 88° to 94° F. Too frequently do we see excessive cold or heat applied to an extremity by a well-meaning but incompetent first aider. In the past year I have seen a massive leg gangrene develop following a minor sprain and the placing of the patient's leg in a baker with a very high environmental temperature (primary arteriosclerosis); similarly, I have seen the development of gangrene which necessitated thigh amputation, following the placing of a man's leg in ice water to relieve pain due to a mild trauma (primary thromboangiitis obliterans).

THERAPY PRINCIPLES IMPORTANT

Several general principles of therapy should be stressed. Heat, one of our most valuable aids, should be used in two forms. Environmental temperature should be low enough to reduce the metabolic process to a point where tissues can survive with the blood supply available. In severe injuries this may mean a temperature of between 50 and 60° F. Temperatures above that of body temperature may be applied to the trunk by contact, irradiation, or electrical energy in order to promote reflex peripheral vasodilatation. Other methods of raising body temperature, such as intravenous typhoid vaccine therapy, will accomplish the same result provided excessive dosage is avoided and chills are eliminated. In passing, various drugs must be mentioned but their importance in treatment is of a minor degree. Nitrites, xanthines, papaverine, cholines, salicylates, and alcohol all have their advocates. None is outstanding in its effect. Hypertonic saline has been demonstrated to increase blood volume and peripheral pulsations. Mechanical appliances, such as the oscillating bed, intermittent venous occlusion, and the suction pressure boot, when used by the experienced, may be of value but their availability is limited and their use must be directed by one skilled in their application. Of all methods so far advocated the oscillating bed[9] is perhaps the most sound in principle, the easiest of application, and the most satisfactory. However, I have seen even this simple modification of the postural exercise principle do harm. If the period of elevation is too prolonged or too high, increased ischemia to the tissues results, pain increases and gangrene extends.

This discussion of therapy would not be complete without a brief review of anticoagulants. Heparin[10] is easily available and its use fairly well standardized. Its immediate use in arterial surgery or in patients with rapidly progressive venous or arterial thrombosis is dramatic. Embolism from venous clots is reduced. It should be available in every operating room and used on the table when vessels are repaired.

Dicoumarol,[10] an oral anticoagulant derived from spoiled sweet clover, necessitating forty-eight hours for its effect, may be used to carry on the effect of heparin or, in chronic thrombophlebitis resulting from an injury, to prevent embolism and help arrest the process. It is still too new and experimental to be turned over to the profession in general.

CONCLUSIONS

I would like to point out that industry can use individuals suffering from peripheral vascular disease, that it is using many without being aware of it and that the physician should be on the alert to discover such disease by careful clinical observation. When such an individual is injured, certain principles of therapy must be observed. The physician must also recognize peripheral vascular

disease as a result of the hazards and accidents of industry.

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DISCUSSION

Dr. John P. Helmick, chairman, Fairmont: Dr. Duryee has volunteered to answer any questions that you may have along this particular line.

There is one question which we talked over at lunch time that I would like to have Dr. Duryee discuss a little more in detail. This concerns the use of heat and its effect on raising the metabolism of the injured extremities by its local application.

Dr. Duryee: I have discussed the reduction of temperatures to meet the metabolic levels of the tissues with reduced blood supply. There are on the market many forms of apparatus to increase body temperature: short wave, radiotherm, infrared lamp, electric pads, and each one of them is a potential source of danger to the individual suffering from vascular disease. Fortunately, the medical profession is beginning to realize, and very definitely realize, that severe damage can be done by applying these modalities of heat to extremities with impaired circulation. Still we see them coming to the clinics with extremities blistered and burned from the effect of excessive heat. One particular form of heat has been especially misused, and that is the short wave. Those of you who know the principles of short wave realize that heat is generated at nodal points. If it is applied to an extremity, an ankle, (illustrating) and the waves are so concentrated that the nodal point is deep in the extremity, one can very easily produce a deep gangrene if the arterial supply is impaired. We see these patients in excruciating pain without any superficial evidence of a burn, but rapidly developing gangrene. On amputation it is very clearly demonstrated that the deep burn precipitated the gangrene.

It behooves anybody who is doing much physiotherapy, if they apply heat to an extremity, to be sure that the arterial supply of that extremity is adequate.

The question of immersion foot was mentioned. Dr. James White who has always been extremely interested in the field of peripheral vascular disease has had the chance to see a great many of these cases since he has been in the Navy as a Commander. In this condition, not very well understood even today, there are several contributory factors. First, there is a long period of dependency with the legs held below heart level for days, sometimes; secondly, constricting clotting, both leading to edema. There may be other factors in producing edema if they exist long enough, such as dietary deficiencies. In addition, there is vasospasm from the chilling. There may be also present shock and a drop in blood pressure. All of these factors lead to thrombosis in the arterioles and venules. This thrombosis will then progress, if not properly treated, to a point where serious gangrene develops. If one brings these individuals into a very warm room or overheats the extremities, he runs into difficulty. It has been found that if one elevates the environmental temperature very slowly, starting at about 50 or 60 degrees F. and continues elevation slowly for three or four days to the normal environmental temperature of around 88 or 90 degrees F., one gets the best results. Reflex vasodilatation can be added to the environmental temperature control by applying heat to the body. Other therapeutic aids such as the oscillating bed, drugs, and the control of pain should also be utilized. The control of pain is one of the greatest factors in overcoming vasospasm. As long as the patient suffers severe pain in an extremity vasospasm increases and morphine, or some of the morphine derivatives, probably constitute the best way of controlling this factor.

The Chairman: Would you discuss femoral ligation for thrombophlebitis to prevent pulmonary infarction? There is also the question of tobacco.

Dr. Duryee: I was afraid somebody would bring up the question of femoral ligation. It has been one of the main points of disagreement among my friends in New York. If there is a thrombophlebitic process in the lower extremity, ligation of the femoral vein or the saphenous, preferably the femoral, will frequently prevent pulmonary emboli especially in certain types of localized thrombophlebitis, but in cases of progressive thrombophlebitis, after you ligate, the process often progresses up the vein, through collaterals, into the iliac veins. I have recently seen four cases of iliac phlebitis following vein ligation.

On the other hand, some of the statistics reported show a reduced number of emboli following ligation. I do not know where I stand on this procedure.

At the Postgraduate Hospital we have practically discontinued vein ligation in thrombophlebitis. There is no evidence that it shortens the phlebitic process. With the use of anticoagulants one can practically eliminate embolism, and therefore this surgical procedure becomes unnecessary.

Somebody brought up the question of tobacco and peripheral vascular disease. Recently most of the cases of vascular disease that I have seen in the office or in the clinic, have been told by their physician to stop smoking, and a great many of them have followed this advice.

I might summarize the present impressions concerning tobacco. I think it is more or less the consensus of workers in this field, that tobacco, *per se*, probably does not produce peripheral vascular disease. On the other hand, it is known and has been demonstrated to produce a high degree of vasospasm, and if you have blood vessels that are already damaged and you cut the blood supply further by vasospasm, then thromboses may form and gangrene may develop. This is particularly true of thrombo-angiitis obliterans. It is less true of arteriosclerosis. In thrombo-angiitis obliterans the spastic element is an important factor. We have made it a policy at the clinic not to treat a clinic patient in the hospital or in the clinic if he continues to smoke. On the other hand, when you have an old arteriosclerotic who has smoked all of his life and his vasospastic factor is small and he is sixty-five or seventy years of age, it may be humanitarian to allow him to continue to smoke to the last of his days.

The Chairman: What is the incidence of cerebral hemorrhage in the use of heparin?

Dr. Duryee: I have never seen gross cerebral hemorrhage during the use of heparin. Evidence of small petechial hemorrhage has been noted. In our use of dicoumarol we had one case which had evidence of a small hemorrhage with mild hemiplegia which cleared completely. These are both dangerous drugs, and like any other potent drug in medicine, must be used by somebody who has had experience and is skilled in their application. Gold has cured a lot of cases of arthritis, but also it has killed a number of individuals.

The Chairman: On behalf of the West Virginia Heart Association, I want to thank Dr. Duryee for his presentation this afternoon.

LIFE BEGINS AT 100

A twenty-year study of 450 centenarians, men and women, reveals that "life for some may begin at 100 instead of 40," it was reported before the meeting of the Eastern Psychological Association by Dr. Grace E. Bird of the Rhode Island State College of Education.

Those individuals who reached or passed the five-score mark, Dr. Bird said, seem to get a "second wind" for the remaining part of their lives.

Most members of the group, Dr. Bird observed, "had definite plans for the future, interest in public affairs, strong enthusiasms, hobbies, a sense of humor, good appetite, and a strong resistance to strain, disease and injuries." Most of them were interested in romance. One woman cynically declared that "she was through with men," but it came out that she was recovering from a disappointing romance with a 77-year-old Lochinvar.

Of the 450 centenarians studied during the last twenty years 340 still are living. Of the 110 who died the median age at death was 102 for both sexes. Married women who passed the century mark had a life expectancy of 103. About twice as many women as men lived to be 100.

The jobs of men and women over 100 are varied and may be strenuous. A woman, at 100, works in her son's candy shop. One man was appointed deputy sheriff at the age of 100.—*The New York Times.*

MANAGEMENT OF THE DIABETIC PATIENT DURING ACUTE ILLNESS*

By HEYES PETERSON, M. D.
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FEW physicians realize how frequently mismanagement of a person with diabetes during a supposedly minor illness will result in coma. While many diabetic patients in acidosis or in coma are not seen by a physician, many are given incorrect or overcautious treatment which leads directly to coma. The natural reluctance of members of the medical profession to criticize a fellow physician's treatment often leaves the first doctor without knowledge of his mistake. Since all of us, however broad or narrow our fields, encounter persons with diabetes, the proper procedure in diabetic emergency is of universal importance.

It happens very frequently that a physician is called by telephone and informed that a diabetic patient has a heavy cold, gastroenteritis, or similar temporary upset and is unable to eat and even may be vomiting. The patient and family are concerned as to whether or not insulin is indicated and, if so, how much. There may be, of course, signs of serious illness warranting the physician's personal attendance; as often as not the family recognizes the disorder as a minor one and merely wishes advice. It is in just such a situation that one may unwittingly invite acidosis and coma with the words, "Not eating?—then stop his insulin until he is able to eat again."

The dietary treatment of many cases of mild diabetes leads to the assumption on the part of patients and their families that insulin is required only to "cover" the sugar eaten as food and that when food is not being eaten insulin is not required. This is, of course, completely erroneous, since diabetes mellitus is a deficiency of the essential hormone, insulin, which every normal human manufactures for himself in his own pancreas. There is a definite insulin requirement for normal body metabolism even in the fasting condition. While it is true that a healthy human being will require less insulin when fasting than when eating, the exact reverse is usually the case in disease, even in relatively mild upper respiratory or gastro-intestinal afflictions. In disease the body's requirement for insulin is usually much higher than in health (whether due to increased insulin resistance in disease, increased demands for insulin in disease, or both) and so the insulin requirement of a sick diabetic person who is unable to eat is greater and may be much greater indeed than the insulin requirement of a so-called healthy diabetic person who is eating well. For these reasons the sick and fasting person with diabetes never should be told to discontinue insulin completely. He should, rather, be placed on a careful routine which will be discussed later.

Of particular importance is proper care of the vomiting diabetic patient. In such a case, continued loss of electrolytes added to the disturbing factors mentioned in the previous paragraph causes a major metabolic upheaval with serious changes in the body chemistry which lead very rapidly to acidosis. The insulin requirement always rises under such circumstances, and it is of enormous importance to give as much extra insulin as is required, since without ample supplies of

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*From the Department of Internal Medicine, Wheeling Clinic.

insulin these patients go into acidosis and deep coma with terrifying suddenness. While it is, of course, important to give such parenteral fluids as may be required for replacement purposes, early, continued, large doses of insulin far outweigh other necessary treatment in importance and urgency.

HISTORY OF TYPE OF SYMPTOMATOLOGY AIDS

Telephone information will help greatly in the management of such problems. A history of the type of symptomatology and rapidity of onset will aid in determining whether the present illness is the culmination of inadequate insulin therapy with progressive acidosis over several weeks, or whether the difficulty is a temporary upset whose onset was not related to the presence of diabetes at all. It is important to know when the patient last visited his physician, how much insulin was prescribed at that time, and particularly how much insulin the patient had been taking during the preceding few days. Results of any recent urine tests, particularly during the present illness, should be reported.

Assuming that the patient is mildly to moderately ill with illness of short duration and with loss of appetite but without actual vomiting, the protamine zinc or slow-acting portion of the total dosage should be given without fail. Should there be dosages of regular insulin or combination of mixtures of insulin, it would be safe and practical to give two-thirds of the total daily insulin dosage as protamine zinc insulin in one injection daily in the morning. A urine specimen should then be tested before each meal and at bedtime in the case of the slightly ill patient and every two hours when the patient is moderately ill or when the urine continues to show heavy sugar and acetone. If the urine specimen shows much sugar and particularly if acetone is persistently present, the examination should be repeated every two hours without fail, day and night, until specimens are free from acetone and relatively free from sugar, and remain so. These specimens should be "covered"—that is, insulin should be given for any showing which amounts to more than a slight trace of sugar. This is given on a definite schedule, and the family might be instructed to give twenty units of quick-acting insulin (regular or crystalline insulin) for a heavy or 4 plus urine sugar, ten units of the same for 3 to 2 plus or moderate, and nothing for 1 plus or light. This "coverage" might be scaled down to sixteen units for heavy reduction and eight units for moderate reduction in the mildly ill whose specimens show no acetone and become sugar-free without difficulty. This "coverage" is given immediately after the examination of every urine specimen, whether every two or every four hours, and is given whether the patient is able to eat or not and whether he is vomiting or not. Such treatment will usually render the urine of a mild or moderate case relatively free from sugar and acetone within half a day. If the specimens continue sugar-free, the time interval between urine examinations might be lengthened during the night, making sure that specimens are examined at least every four hours without fail during the period of illness.

Every diabetic person and at least one member of his immediate family should be able to test urine for sugar. There are convenient testing kits on the market which can be mastered by anyone in a short time. Among these might be mentioned the Sheftel urine sugar test case made by Eli Lilly and Company, the Galatest urine testing kit of the Denver Chemical Manufacturing Company of New York, as well as the Benedict's test and other satisfactory methods.

HOSPITALIZATION NOT ALWAYS PRACTICAL

The seriously ill and particularly the vomiting patient would probably be seen by the physician but in any case he should be immediately placed upon a one-hour urine schedule with urine "coverage" as noted previously. In addition, the full daily dosage of insulin should be given without fail. While such patients are cared for more satisfactorily in the hospital, hospitalization is not always practical and may be dispensed with as long as hourly check is kept on sugar and, if

possible, on acetone in the urine specimens. If hourly "coverage" does not suffice to cause a marked decrease in the amount of sugar in the urine, such coverage should be doubled, tripled, or increased to as much as is required to cause a noticeable drop in urine sugar and to maintain the urine relatively free from sugar. There seems to be a general and wholly false assumption that it is better to have the patient run a little sugar to make sure the insulin dosage is not too large. The dangers of overdosage with insulin in this type of patient are so minimal compared with the enormous dangers of underdosage that the doctor should strive rather to keep the urine acetone-free and nearly or completely sugar-free. It will be found extremely difficult to cause a reaction or any symptoms of insulin overdosage, since these patients tend to be unusually refractory to insulin treatment and have a high insulin requirement.

The patient who has been drowsy, weak, and who has had vague abdominal distress for a week or two preceding the present attack should be watched with particular care; such symptoms usually indicate that he is suffering from diabetic acidosis itself rather than any coincidental disease. Upon discovering a patient to be in diabetic acidosis *per se*, he should be treated as a case of frank diabetic coma until out of danger.

DIABETICS OFTEN OVERTREATED

One often hears physicians comment to the effect that persons with diabetes are frequently overtreated and that they themselves prefer to have their diabetic patients run a little sugar in the urine. While this sort of treatment predisposes to the early appearance of diabetic retinitis, diabetic cataracts, extensive arteriosclerosis, and the other degenerative changes characteristic of the uncontrolled or poorly controlled diabetic patient, it is nevertheless true that many patients with mild to moderate diabetes can continue symptom-free and in what appears superficially to be good health when controlled in such haphazard fashion. It is vitally important that this habit of thinking be not carried over to include the diabetic person suffering from acute illness, however, since it will always result in poor recovery and will sooner or later lead to disaster.

OVERDOSAGE vs. UNDERDOSAGE

The timidity of most physicians with respect to insulin dosage and their fear of the consequences of overdosage would be entirely removed were they able to observe the relative impunity with which psychiatrists use several hundred units of insulin routinely in insulin shock therapy. Granting that the effects of overdosage of insulin are unpleasant and might be dangerous and that the chronic overdosage of a healthy diabetic is as little to be desired as the chronic underdosage of the same person, it is nevertheless true that the person with diabetes who is suffering from intercurrent disease is in infinitely more danger from underdosage than from overdosage and is indeed difficult to overdose. Less regard of insulin as potential dynamite and more regard for it as the essential, vitally necessary, and life-giving hormone that it is will be a great boon in the general treatment of diabetes.

SUMMARY

Many diabetics are allowed to go into acidosis and into coma because of undertreatment during the course of an intercurrent infection. Practical instructions are discussed so that the diabetic may be nursed through his illness with safety and with a working approximation of his insulin requirements.

NEED FOR HEALTH MEASURES

Some federal departments maintain emergency rooms, but almost all of them lack the services of a physician. There is no uniformity in the type of medical service offered by different departments. Sometimes nurses do little more than check up on malingering on the part of government employees. In spite of the fact that the government is urging private employers to adopt industrial hygiene programs, and in spite of the fact that the government is now the largest employer in the nation, it lags far behind progressive corporations in protecting the health and lives of its employees. — *Washington Post.*

A NEW CAUSE OF METATARSALGIA

(Report of a Case)

By HOWARD A. SWART, M. D., F. A. C. S.
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METATARSALGIA is the term given to the condition characterized by pain across the metatarsal arch of the foot. The disease is divided into two types. The pain incident to the first type usually can be relieved by placing a bar of leather across the sole of the shoe just back of the metatarsal arch. The pain associated with the second type, known as Morton's toe, is more severe and intractable. It occurs mostly in women and when a spasm of pain comes on the patient must take her shoe off and rub the foot. This pain seldom has been relieved by metatarsal bars or any other type of shoe correction.

It was in treating a patient with the second type of metatarsalgia that a new cause for it was found.

CASE REPORT

Mrs. O. G., white female, aged 24, had been first seen by me in 1940 because of metatarsal pain of the right foot. A metatarsal bar had given very little relief and she had consulted other doctors as well as chiropodists without securing any benefit.

She returned November 11, 1942, stating that the pain was much worse and demanding that something be done. Ordinarily these patients are more comfortable in low heeled shoes, but this patient could not wear any type of shoe excepting a bedroom slipper.

Examination revealed tenderness on compression across the metatarsal arch. There was no swelling or stiffness and x-rays of the foot were negative.

The author had heard, as a medical student, that sometimes it became necessary to resect the nerves to the toes in cases of intractable metatarsalgia and, as a last resort, this measure was proposed. The patient agreed to undergo operation which was performed on November 30.

Through a 3 inch longitudinal incision on the dorsal surface of the foot, centered over the third metatarsal bone, branches of nerves running to the fibular side of the second toe, both sides of the third toe and tibial side of the fourth toe were resected. The nerves were not abnormal in any way.

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A similar incision was made on the plantar surface of the foot. At this time it was found that in the nerve running to the third metatarsal bone there was a firm, glistening, white tumor mass the size of a large pea. This was thought to be a neuroma and was excised.

Following the operation, the patient's pain was completely relieved and has remained so. There was some anesthesia of the toes but this was to be expected.

The pathological report on the excised tumor mass was "fibrous tissue with regressive changes."

At the annual meeting of the American Academy of Orthopedic Surgeons held in Chicago in January, 1943, Dr. Robert T. McElvenny[1] of Chicago read a paper on this subject in which he described exactly the same condition as found in the author's patient. He had had eleven cases, all relieved by resection of the tumor. He said that it occurred most commonly on the lateral branch of the medial plantar nerve.

Pathologic studies had been carried out in five of his eleven cases and neurofibromata or angioneurofibromata had been found. He stated also that a number of pathologists had studied sections from the tumors and that there had been no agreement as to their exact nature.

Dr. McElvenny said that he had made a very thorough search of the literature and had found only one article in which this con-

dition was described. Betts[2] of Australia had written of the disease in 1940. He had found the tumor in the same location and had produced relief of pain by resecting it. Betts stated that he had performed the operation in twenty-five or thirty cases.

CONCLUSIONS

It seems evident that severe intractable metatarsalgia, or Morton's toe, is caused certainly in some instances, by a tumor involving the lateral branch of the medial plantar nerve of the foot. The exact nature of the tumor is uncertain at present, but relief of pain can be dramatically and permanently produced by resection of the tumor.

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SIMMONDS' SYNDROME (PITUITARY CACHEXIA)

(Report of a Case)*

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In modern endocrinology "all roads lead to the pituitary." The early anatomists, including Galen, were fascinated by the snug inclusion of this organ in the bony shell of the sella tursica and by the close anatomical relationship it bore to the other structures in the region of the circle of Willis. Speculation as to its probable function was varied. Most early thinkers ascribed vague humoral properties to the structure. This was not a bad guess in the light of modern knowledge. In the latter half of the sixteenth century much interest was aroused by the new science of comparative anatomy. Many structures known to have active function in lower animals were observed to be vestigial in more highly specialized forms. The pituitary was considered a vestigial organ and given the name "hypophysis." In the year 1886, Pierre Marie described the skeletal changes of acromegaly. Autopsy of such malformed individuals revealed an adenomatous growth in the region of the anterior lobe of the pituitary. About the same time gigantism was recognized as a similar condition affecting a different age group. The pituitary was recognized as playing a vital part in the dual process of growth and development. The revival of interest in the pituitary was kindled by descriptions of various types of dwarfisms, infantilisms, and genital dyscrasiæ from the clinics of the leading medical men of the time. At the turn of the twentieth century interest in the pituitary was intense, and the development of analytical biological chemistry ushered in the hormone age and debate and discussion were intensified by ever increasing research.

The anatomy and embryology of the pituitary are well known. Genetically the human pituitary follows a pattern common to all mammals. It is a structure of dual origin, being formed from an outpouching of the buccal mucosa (Rathke's pouch) and a downward projection of the floor of the diencephalon. A simple stalk connects the latter, posterior lobe, with the midbrain while the anterior portion looses its contiguity with the pharynx. Normally the buccal epithelium dis-

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*From the case records of the Logan General Hospital.

appears but on occasion persists with cyst formation (Rathke's pouch cyst). The anterior lobe is differentiated from the posterior not only embryologically but also histologically. A small pars intermedia, thought to be without function, separates the two lobes. The anterior lobe, representing the portion derived from the buccal element, contains three distinct types of cells: chromophobe (resisting stain), and chromophile (easily stained) which is further divided into eosinophile and basophile elements. The posterior lobe consists of glial cells and medullated nerve fibers which descend from the diencephalon by way of the pituitary stalk and terminate in a plexiform arrangement in the lobe. The anterior lobe is considered by endocrinologists to be the functionally important portion of the gland.

PITUITARY LITERATURE

Literature on the pituitary is absorbingly interesting but very confusing. It is now recognized that the anterior lobe function controls not only growth and development but also exerts a profound influence on the whole endocrine system. It has aptly been called "the keystone of the endocrine arch." Many conditions, some of them little understood, have been ascribed to disease of the pituitary, and endocrine imbalance may result in a large number of similar conditions with different clinical aspects because of the close interrelationship of the various endocrine activities. Anterior lobe dysfunction results in a large number of conditions the consideration of which is beyond the scope of this paper. Anterior lobe dysfunction causes the most widespread dislocation of endocrine activity because of the real dependence of the other endocrine glands: thyroid, adrenal, pancreas, ovary, testis, thymus, and pineal body on this portion of the pituitary. This is most clearly demonstrated in cases of destruction of the anterior lobe in which condition the clinical picture is that of a polyendocrine deficiency.

Attention was first called to anterior lobe failure in 1914 when Simmonds described a syndrome which he termed "cachexia hypophysiopriva." The resulting cachexia was characterized by features not found in the general emaciation of chronic infectious or neoplastic disease. Simmonds set down salient features of this condition: precocious senility, dental caries, low basal metabolic rate, decrease in size of the vital organs (splanchnomicria), loss of pubic and axillary hair, and loss of libido and sex function. His report of a case of "Pituitary Atrophy with Fatal Outcome" mentioned the importance of demonstrating actual pathology in the pituitary by autopsy if possible and careful ruling out of tuberculosis, carcinoma, and psychogenic starvation states such as anorexia nervosa before concluding any case of advanced emaciation as secondary to anterior lobe failure. Other clinical features are loss of hair and teeth, atrophy of the sex organs in both sexes and of the breasts in the female, atrophy of the thyroid, lowered blood sugar values with marked tendency to hypoglycemic crises, insulin sensitivity of extreme grade, subnormal temperature, atrophy of the adrenal cortex, depression of the total blood chlorides and blood sodium, hypotension, mental apathy, and psychic depression. The primary pathology is a tumor, cyst, infectious process, or hemorrhage which destroys (usually by pressure) the anterior lobe cellular elements. This condition is prone to occur in women between the ages of thirty and forty, and its clinical features are similar to the multiple ductless glandular sclerosis of Falta and Von Bergman's pituitary magersucht (emaciation) which is reported to occur in young girls at puberty. In the case presented, destructive processes are evident in the region of the pituitary by rontgenogram. The resulting clinical syndrome may correctly be classed as a polyendocrine deficiency, because hypofunction of the thyroid, ovaries, and adrenals is present and resulting physical changes are evident to the clinician.

CASE REPORT

History: The patient, a white female, 42 years of age, complained of progressive weakness with

loss of weight for the past four years. For the preceding three months she had been having "spells" in which she had lain semicomatose for from two to three days. She had been bedridden for weeks. She was so weak she could barely walk. Her appetite was poor, but there was no nausea, no vomiting and no pain.

In 1929 she had slight hemoptysis and was told she had tuberculosis. She rested and made a good "recovery." In 1938 she was admitted to the hospital with a diagnosis of pneumonia. Secondarily, she developed an otitis media and a subsequent mastoiditis for which a mastoidectomy was done. In 1939 she began to lose her pubic and axillary hair. She believed her weakness began about that time. Her optimum weight was 126 pounds.

She began to menstruate at the age of 12 and was married at 17. In 1919 she lost her first pregnancy by placenta prævia; her second went to full term; her third miscarried in 1921. This was followed by a long illness and her menstrual periods were never normal afterward. There were a few scant periods for two years after which she stopped menstruating entirely.

The family history was unsatisfactory. Parents died of "old age." Two siblings are living and well. No history of tuberculosis, cancer, diabetes, or insanity.

The review of systems gave the following information: Upper respiratory: Frequent colds, hemoptysis, pneumonia and complications as above. Genito-urinary: No edema of face or extremities, no hematuria, no frequency, no pain. Gastrointestinal: Appetite always poor, no diarrhea, no nausea or vomiting, no melena, no hematemesis. Cardiovascular: No edema, no palpitation, no precordial distress, no shortness of breath. Neuromuscular: Progressive weakness and loss of weight, no paralysis, no visual disturbance, no double vision, no anesthesias or paresthesias.

Physical Examination: Temperature 97 F. Pulse 60. Blood pressure was 70 systolic and 50 diastolic. Weight 65 pounds.

General appearance: Patient is a white female about 45 years of age. She is extremely weak and walks with great difficulty though the gait does not differ from the normal excepting the weakness and slowness of muscular motion. The skin is coarse and dry with a yellowish tint; no areas of pigmentation are present, and the skin fits the body snugly. Hair of scalp is sparse, very dry, and coarse in texture. No pubic or axillary hair is present. There is striking general emaciation. Patient is fairly alert and tries to cooperate. She answers questions well but slowly.

Scalp and skull: There is a well-healed scar 4 cm. in length behind the left ear and a depression in the left mastoid bone 3 cm. in diameter. The skull is otherwise negative externally.

Eyes: React to light and accommodation. Pupils are round and equal in size. External ocular movements are well executed. No nystagmus or strabismus is present. Visual fields are normal by rough test. Eyegrounds show slight pallor of the nasal margin of the discs but are otherwise normal.

Ears: There is a large central perforation of the left drum. There is no discharge. The right drum is normal.

Nose: Mucous membranes are pale but otherwise normal.

Mouth: Dentures, both upper and lower; pale mucous membranes but with no pigmentation. The tongue is slightly coated. There is no atrophic change of the margins and no ulceration; it protrudes in the midline and a fine tremor is present.

Throat: Tonsils are small. There is no postnasal discharge.

Neck: No rigidity, no palpable glands, the thyroid is very small, and there is a slight tracheal deviation to the left.

Chest: Resonant to hyperresonant percussion note throughout. A few faint musical râles are heard anteriorly at the left apex. The heart is small with the heart sounds barely audible. No thrills and no murmurs noted. Rate is slow but regular, and both radial pulses are synchronous and weak.

Abdomen: Extreme scaphoid type, no masses, no tenderness, no scars, no rigidity.

Back: Slight postural scoliosis to the right in the lower thoracic vertebræ, no tenderness in either lumbocostal region.

Pelvic: Uterus very small, no adnexal masses; cervix is small and dry, no discharge; the vaginal mucosa is smooth and atrophic.

Rectal: Negative.

Extremities: Motion in the joints good, no pretibial edema; the temperature of the hands and feet approximately the same as that of the trunk. Nails are pale but in good condition.

Neurological: Deep reflexes present but sluggish. Romberg and Babinski absent. There is general muscular weakness.

Laboratory work: Erythrocytes 4,300,000, leukocytes 7,800, polymorphonuclear 68 per cent,

lymphocytes 28 per cent, hemoglobin 80 per cent (Tallqvist). Urinalysis showed the specific gravity to be 1.020, reaction acid, albumen negative, sugar negative, two to three white blood cells, no red blood cells, no casts. Blood sugar 59 mg. per cent, nonprotein nitrogen 22 mg. per cent, blood chlorides 200 mg. per cent. The Kahn test for syphilis was negative.

X-ray examination of the skull showed destruction of the posterior clinoids and encroachment upon the sellar space by new bone formation. There was some distinct calcification visible within the sellar space suggesting actual calcium deposition in the pituitary. There was an area of new bone formation in the left mastoid bone with no air cells visible in this bone.

X-ray examination of the chest showed some small calcified areas at both hili with some increase of the hilar markings bilaterally but no change suggesting any active pulmonary disease.

Progress: The patient was admitted to the hospital on August 12, 1943. She was placed on a soft high caloric diet. Sodium chloride (enteric coated tablets) grams 1 was given every four hours. She was given thyroid 3 grains three times a day. Eschatin was given, 2 cc. subcutaneously every four hours. The first dose of eschatin was given intravenously in 1000 cc. of 10 per cent glucose in normal saline. The patient responded immediately to the glucose and became very alert and active. She ate well and said she felt fine. The second day she was given a 3 mg. ampoule of stilbesterol subcutaneously twice a day. She lapsed into a hypoglycemic crisis and was semicomatose at the end of the second day. Glucose by vein revived her immediately. The patient vomited on the morning of the third day and both salt tablets and stilbesterol were discontinued. She was given thyroid and eschatin for a week without visible improvement. Her temperature continued subnormal but did rise to normal following an intravenous injection of glucose or a meal. She suffered several hypoglycemic crises. Her blood pressure varied between 66 systolic, 48 diastolic and 74 systolic, 52 diastolic. She was then placed on anterior pituitary extract (Parke-Davis), 1 cc. every twelve hours and the eschatin was discontinued. She began to show improvement two days later. Her hypoglycemic crises stopped, but 8 ounces of saturated solution of sucrose was given every four hours as a safety measure. On August 27 the patient asked to be sent home. She said she felt greatly improved and her appetite was much better. Her blood pressure at this time was 80 systolic and 52 diastolic. She was discharged taking thyroid 3 grains three times a day and anterior pituitary extract, 1 cc. once a day.

It would have been interesting to try this patient on the new drug known as desoxycorticosterone, but none was available. Whether her vomiting was due to the salt or the relatively large doses of stilbesterol was not determined. The thyroid may have played an entirely neutral rôle but was continued because of the patient's very poor metabolic condition. No tests for insulin sensitivity were carried out. Facilities were not available for protein metabolism studies. Improvement following the anterior pituitary extract was minimal but very encouraging to the patient. Eschatin, an excellent adrenal cortical extract, seemed to have little, if any, value in the hypotension presented by this case.

SUMMARY

A case of Simmonds syndrome is presented. The etiology is probably destruction of the peripituitary bone and pressure upon the pituitary, if not actual calcification of it, by new bone formation. It would seem that this followed an extension of the mastoid infection into the region of the sella tursica. The smoothness of the skin of the axillæ and mons veneris with complete loss of hair suggested disease of the pituitary. The x-ray of the sella was striking in the changes seen. A method of treatment is described.

YOUR PHARMACIST WILL COOPERATE

Physicians will obtain better service if they will cooperate with pharmacists in the following ways:

When medicines are needed quickly, much time can be saved if the physicians will telephone the pharmacy so that prescriptions may be ready when called for or their delivery expedited.

Considerable loss of time and effort, as well as expense, can be avoided if the physician will cooperate fully in the observance of federal regulations governing the prescribing of codeine and similar drugs. The physician and the pharmacist are both required by law to furnish and record properly written and signed prescriptions for such orders promptly. Telephoned prescriptions, accepted by the pharmacist in good faith, too frequently add to his difficulties because of the time and effort required to obtain the written prescription.

Tuberculosis Abstracts

Furnished Through the Courtesy of the West Virginia Tuberculosis Association

In the life of any individual the sudden spitting of blood is a dramatic and fear-stirring event. Usually it is brought to the attention of the physician so promptly that an accurate and rapid diagnosis is possible. Self-neglect, however, is encountered on the part of some patients. Errors in diagnosis, too, are not unheard of happenings. Thus there is every good reason why such an alarming symptom as hemoptysis must be viewed with concern by the doctor until the cause has been established and the proper emergency care and long-term treatment provided.

Hemorrhage in Pulmonary Tuberculosis

Pulmonary hemorrhage is one of the most distressing phenomena encountered in medical practice. The patient is gravely alarmed and the physician is confronted by bleeding that comes from a point deep within a delicate organ enclosed in a rigid framework. To combat the bleeding there may be only slowly or doubtfully effective physiological mechanisms.

Psychological effects to one side, hemoptysis generally is indicative of serious pulmonary disease. It is recognized that unexplained blood-spitting must be considered due to tuberculosis until proved otherwise. However, occasional causes include such nontuberculous disease as bronchiectasis, bronchogenic carcinoma, lung abscess, rheumatic heart disease and various minor nose and throat affections. People apparently in good health and presenting negative physical signs and few or equivocal roentgen findings represent especially puzzling problems when they report having coughed up blood. In all cases it is essential that we exhaust every means at our disposal of tracking down the reason for obscure lung hemorrhage.

The causes of hemoptysis are still not clearly understood. Blame has been laid on deficiency in one of the factors concerned in blood coagulation, on tonic, nervous or endocrine factors, on erosion of a vessel wall by a tuberculous process, on rupture of a small aneurysm within a cavity. While the most serious hemorrhages occur in old, fibro-ulcerative tuberculosis, small or moderate hemoptyses may be seen in early disease, sometimes as the first recognizable symptom. Softening of a lesion or progression of an established process may be accompanied by hemorrhage.

Among 1,000 patients consecutively discharged from the Blue Ridge Sanatorium, Charlottesville, Virginia, only those were included in this study who gave a clear-cut history of spitting up one dram or more of blood, or who suffered a hemorrhage during their stay in the institution. "Streaking," "streaked sputum" and indefinite history of hemoptysis were excluded. In all, 905 cases of tuberculosis, made up of 424 males and 481 females, included 220 who had hemoptyses during the active phase of the disease. This is an incidence of 24.3 per cent, regardless of the duration of observation.

Some of the largest hemorrhages in this series occurred in a few patients showing bronchiectasis or rheumatic heart disease. Bogen, including instances of streaks and clots, found that over half of his hemoptysis cases expectorated less than two ounces of blood. The present study records 106 hemorrhages of stated amount, ranging from one dram to two quarts, the average being five ounces. This did not include repeated bleeding from the same individual on the same or subsequent days, since these were not felt to be distinct episodes, but more or less a continuation of the first. In approximately 40 per cent of the cases the episode of hemoptysis was repeated at least once.

Hemorrhage was the presenting symptom, often the initial evidence of trouble, in 60 cases. Perhaps nothing drives a patient to seek medical advice faster than the expectoration of a single mouthful of blood, although 23 patients did nothing about their initial hemorrhage.

When the local physician was consulted by persons with hemorrhage in cases of previously undiagnosed tuberculosis 70 per cent were properly diagnosed, though it is estimated that 84 per cent correct diagnoses could have been reached by further study.

Only 49 cases in the entire hemoptysis group failed to show a cavity on x-ray examination and of these 11 were found to be nontuberculous. No less than 83.4 per cent of the tuberculous cases with hemorrhage had a positive sputum! Of the 170 patients in this latter category, 159 had roentgenograms revealing consolidation, honey-combing, punching out or frank cavitation.

Correlation of hemoptysis with physical exertion,

(Continued on page xxx)

The President's Page

In the December, 1928, issue of the WEST VIRGINIA MEDICAL JOURNAL there appeared the first President's Page. It was written by our late beloved, Dr. C. A. Ray, who stated that the secretary of the society had suggested the idea to him. The custom has continued to this date. I do not know who our secretary was at the time. It may have been Joe. However, I have always felt that our old friend, Jim Bloss, was the instigator. Now to old Jim, Harry Hall, Walter Vest and perhaps a few others, the preparation of this page was a real pleasure, but I have a hunch that to the rest of the boys it has been a headache. If I have misjudged any of my illustrious predecessors, they will please forgive me, but let me assure you that if I am not already crazy, it will only be a matter of months.

In spite of the fact that I have been intensely interested in the affairs of our Association for the past fifteen years, I am a real neophyte in the company of the worthy men who have preceded me. Bob Wilkinson, in his president's page for December, must have been filled with the milk of human kindness to pay such a glowing tribute to your humble servant. To fill his shoes is a job I would wish on no man. Under his able guidance, the Association has taken a great step forward, especially in the field of medical economics, and I wish to assure not only him, but all the members of the Association, that I shall make every effort to bring to fulfillment the plans he has laid and the work he has initiated while serving so ably as your president.

The year 1944 should be one of the most eventful in our nation's history. We hope to see the end of the European war as well as tremendous strides toward the destruction of the Japanese empire. The home front however must not be overlooked. No small part of that front is in the fight to defeat the plan for the complete socialization of medicine. This is no time for small talk and petty differences. The medical and hospitalization aspects of Senate Bill 1161 might never have been included if the medical profession, a few years back, had been alive to the demands being made by the wage earner for some plan for prepaid medical and hospital insurance. Now many plans have been adopted and are proving highly successful.

Our Fact Finding Committee has done a great job and has made recommendations that I trust will be wholeheartedly approved by the members of the Association. Let's not bicker over details, but give to the people generally something they have been clamoring for, and are entitled to receive. By so doing, we will deprive the federal government of the pleasure of doing it for us. I hope it is not too late.

This is the New Year and to you, our brethren in the military service, I wish a most successful, safe, and happy New Year. It is our sincere hope that it will not be necessary for you to be away much longer and we all look forward eagerly to that day when you will be coming home. The best of luck always.

For those of us safely at home, I wish for you strength, health, and courage to meet the daily tasks put before you, to give unstintingly of your time for the relief of human suffering, to avoid selfishness and self-satisfaction, and to work as one united body for the betterment of the health and happiness of man.

President.

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SYMPOSIUMS ON MALARIA

A suggestion has been made by Dr. Harry G. Steele, of Bluefield, first vice president of the West Virginia State Medical Association, that district symposiums on tropical diseases be arranged, with particular emphasis on malaria. The meetings could be called for some central place in each of the six districts, preferably to begin at an early hour in the evening so as to allow plenty of time for roundtable discussions.

The point is made that malaria undoubtedly will be one of the diseases that will follow our boys home from tropical zones. There seems to be no way to avoid it and, it will be no respecter of states, zones or climates.

Forewarned is not always forearmed, but in this case we believe that a few hours spent by every doctor in West Virginia at a county or district symposium devoted to the treatment and control of malaria and other tropical diseases would prepare him the better to cope with these diseases should they appear in his community.

Already members of the staff at Ashford General Hospital at White Sulphur Springs, who are thoroughly familiar with modern methods of treatment, have appeared before the Kanawha and Mercer county societies, and possibly others. These doctors who have met malaria face to face have stated that they are willing to give the doctors of this state the benefit of their own experience and knowledge whenever and wherever possible.

We hope that serious consideration will be given by the officers of component societies to Doctor Steele's timely suggestion.

THE PRESIDENT, 1943 AND 1944

Today, January 1, 1944, Dr. Robert J. Reed, Jr., of Wheeling, takes office as president of the West Virginia State Medical Association. He succeeds Dr. Robert J. Wilkinson of Huntington, who automatically becomes chairman of the Council.

DR. R. J. WILKINSON

Dr. Wilkinson and Dr. Reed have the very best interests of the Association at heart. They have worked shoulder to shoulder in Association affairs. There will be no revolutionary change in policies under the new administration.

Dr. Wilkinson who succeeded Dr. R. O. Rogers as president last January has waged

an aggressive campaign to help keep West Virginia's medical practice in step with the times, or, better, one step ahead. During his term of office he has tried diligently to coordinate the various activities of the Association, his idea being to have all committees and all societies work as a unit towards a definite end. In this he has succeeded. The organized fight against the Wagner-Murray bill, statewide in scope, is an example of what can be done by a united, closely knit organization.

Dr. Wilkinson retires as president with every reason to be proud of the record of his administration. He has the good will of all the members of the Association. He assumes the chairmanship of the Council with full knowledge that continued planning is necessary, but with an expressed willingness to continue to fight for all those things which he deems essential to the welfare of the members of his profession.

DR. ROBT. J. REED, JR.

Doctor Reed assumes his new duties at a time when continued careful charting through troublous seas is of vital importance. He is eminently qualified both by nature and training to handle efficiently the affairs of the office. He takes over with the solid backing and united support of all the members of the Association.

While our new president is not the seventh son of a seventh son, he is the worthy son of a worthy sire. He was brought up in an atmosphere of the highest type of medicine. His father, Dr. Robert J. Reed, a former president of the State Medical Association, is now 84 years of age and still engaged in active practice with his son. His great grandfather, Dr. W. J. Bates, served as the first president of the Association.

Doctor Reed is endowed with all those qualities that are so much to be desired in the active head of a large organization. He is young, vigorous, fearless and outspoken in his convictions, but willing to seek and take advice. He has the best wishes of all the members of the Association for a successful term.

MEDICAL SOCIOLOGY

We always enjoy the *Journal of the Association of American Medical Colleges*. While its concern is essentially medical education, every issue presents something of interest to the general medical man in active practice. An especially thought-provoking article in the November issue is "The Social Aspects of Medicine," by A. M. Lassek, M. D., Professor of Anatomy in the Medical College of the State of South Carolina. Dr. Lassek defines the aim of medical education as "the training of the ideal physician." He feels that our present trends in medical education produce graduates who are "probably the best trained physicians in the world on all phases of organic disease," but so deficient in the social aspects of medicine as not to see, for instance, that the chief cause of disease is poverty with its corollaries—slums, malnutrition, prostitution, alcoholism, and crime. He believes it is "imperative that we think

in terms of health for all our people rather than on organic disease alone, which means curative medicine and the salvaging of the wrecks." His suggestion is that the social aspects and implications of medicine can best be taught in medical schools and by medical teachers, and that we should add to our medical curricula courses in medical sociology.

We have long been of the opinion that physicians hold themselves too much apart from the life of the community in which they reside, and that they do not participate in community activities as they should. Whether this attitude of aloofness is a by-product of the stringent ethics of medicine is a moot question. One of the basic reasons may be the fact that curative medicine is so extremely individualistic. But whatever the cause, Dr. Lassek has presented a phase of medical education and medical practice which should be given serious consideration not only by medical educators, but by the organized profession as well. We quote:

"There is a saying to the effect that any organization that is constantly on the defensive is on the way out. If we are to survive as an integrated, standardized body, we may have to shift from a defensive to an offensive program. This might be concerned with the training of the social as well as the scientific physician. If this is done at all, it would be performed best in medical schools. If poverty, which is a social and economic phenomenon, looms large as a cause of disease, then we cannot neglect it medically. Working with those who are attempting to eradicate unemployment, which will undoubtedly continue to be a national problem after the war, studying and living and working conditions of the people with low incomes, encouraging group practice, and putting the main emphasis on prevention rather than cure is thought by many to be a possible approach. Social research and medical statistics done by medical teachers and members of the profession are bound to show that the problems of health are intricate and that we are largely not responsible for the overall situation. A course in medical sociology, stressing the relation of medicine to society and society to medicine, may be an important course in the medical curriculum. Bardeen advocated this step eighteen years ago. This would not establish a precedent. Recently, a chair of sociology was instituted at the medical school of Oxford University in England and such chairs existed at the universities of Bonn and Frankfort several decades ago. There will be those who claim that our curriculum is already too crowded; but if we do not immediately take steps to train students in this aspect of medicine it seems strongly possible that control of medicine will pass ultimately from the hands of the medical profession on to the laity and politicians. A big step has already been taken in that direction because the laymen are looking at the matter from the social viewpoint, whereas, medical men are thinking in terms of organic disease."

LET'S BUILD A FENCE

The Nassau Medical News, official organ of the Nassau County (New York) Medical Society, in discussing the Wagner-Murray bill, quotes Joseph Malins as follows:

"Better put a strong fence 'round the top of the cliff,

Than an ambulance down in the valley."

Continuing, the editor says that "the American people, following the bait of 'something for nothing' are being lured to the edge of the cliff of totalitarianism. If the bill to bring medicine and the hospitals under political control is once enacted into law, the ambulance at the foot of the cliff will never repair the damage. No nation once shackled with the might of such a political machine would ever be able to throw it off."

The News feels that the doctors themselves must erect the fence at the top of the cliff. "If every doctor," it says, "would take five minutes once each day to point out to an influential patient the true significance of this threat to the patient's own well being, the resulting 'fence' of public opinion would soon be strong enough to hold back an avalanche.

"Few indeed are the people who would vote away their medical birthright if they knew what they were doing. But all too many are deceived by the glittering promise of something for nothing when they are not taught what lies behind the oily smile with which the bait is offered."

COMMITTEE TO CONTINUE WORK

The appointment of a fact finding and planning committee may very well be considered one of the real outstanding acts of Dr. R. J. Wilkinson while serving as president of the State Medical Association. It is now most interesting to know that the new president, Dr. Robert J. Reed, Jr., of Wheeling, has continued this committee in power. Certainly its accomplishments thus far have been such as to warrant its existence at least for another year.

The members have labored long and hard to evolve a satisfactory prepayment medical service plan that will provide adequate medical care for every community in West Virginia. They have given to the Association a basic contract to be used by component societies as a form of prepaid medical service plan to be sponsored by the doctors and administered by hospital service plan groups.

A way must be found to provide adequate medical and hospital care for the indigent. The committee feels that this is a matter that should be handled by county authorities. It is hoped that the committee will, in cooperation with committees appointed for the purpose by county medical societies, continue its study of this perplexing problem to the end that proper medical care may be provided locally for all of the people, regardless of their financial status.

RELOCATION OF DOCTORS

The following interesting summary of the action taken by both branches of Congress on the proposal to appropriate funds for the purpose of supplying medical care for civilians in critical areas was prepared by Mr. J. W. Holloway, director of the Bureau of Legal Medicine and Legislation of the American Medical Association:

Under date of October 1, the President transmitted to Congress supplemental estimates for the United States Public Health Service, amounting to $4,427,550. It was contemplated that of this total $1,000,000 would be used by the service to supply medical care to civilians in critical areas. Such care, it was proposed, would be supplied in one of two ways: (1) by the assignment of medical officers of the service to such areas to treat civilians under a fee schedule agreed on by the service and the State Department of Health; or (2) by inducing civilian physicians to relocate to the critical areas by paying them a relocation allowance of $250 a month for three months plus moving expenses.

These estimates were referred to the House Committee on Appropriations which refused to include in the First Supplemental National Defense Appropriation Bill for 1944 (H.R. 3598) the requested funds for supplying medical care to the critical areas and justified its action as follows:

"The committee in rejecting the budget request does not minimize the need or the seriousness of the situations which exist. It does hesitate to inaugurate a program of this character with Federal funds to provide direct medical attention to the civilian population with physicians paid by the Federal Government. The committee has the opinion that out of the cooperative efforts of the Federal Government, the medical associations, the state departments of health, and the communities themselves, there will and should come a concerted and spontaneous effort to provide this need. Most of it is in war industry areas and it is inconceivable that such communities working with the industries, the affected population, and state and local authority, cannot inaugurate and maintain an adequate public-spirited program, financially sound, to serve this need. If the affected areas cannot and will not solve their local needs it may be necessary for the Federal Government in the interest of the general public health to step in, but until then the committee feels that Federal funds should be withheld under the contemplated procedure."

In the Senate, H.R. 3598 was amended, at the instance of Senator Russell of Georgia, to authorize an appropriation of $345,000 for use by the Public Health Service in providing medical care to civilians in critical areas subject to the following conditions and restrictions:

"Provided, That the Surgeon General is authorized, on application of a municipality, county, or other local subdivision of government duly approved by the state health department having jurisdiction

over said municipality, county, or other local subdivision of government to enter into agreements with private practicing physicians and dentists under which, in consideration of the payment to them of a relocation allowance of not to exceed $250 per month for three months and the actual cost of travel and transportation of the physician or dentist and his family and household effects to the new location, such physician or dentist will agree to move to and engage in the practice of his profession in such area for a period of not less than one year: Provided, however, That no such contract shall be made with any physician or dentist unless such physician or dentist shall be admitted to practice by the state authority having jurisdiction of such new location: Provided further, That each such applicant subdivision shall contribute $100 to the total cost of such relocation allowance, travel, and transportation costs of each such physician or dentist and his family obtained by said applicant."

The bill passed the Senate with this amendment in it. It will now be considered by a conference committee composed of representatives on the part of the House and on the part of the Senate, in an effort to adjust the differences in the bill as it passed the House and as it passed the Senate.

* * * *

In the discussion that preceded the adoption of the amendment, it is interesting to note that many senators desired assurance that the amendment in no way involved the socialization of the practice of medicine. This discussion is given in full in the Congressional Record for December 8, 1943.

DR. McCLINTIC UNDERGOES OPERATION

Dr. C. F. McClintic, former state health commissioner, and now actively engaged in the practice of medicine at Williamsburg, is convalescing from an operation performed at Laird Memorial Hospital, Montgomery, on December 6. It is expected that he will be able to resume his practice within the next few weeks.

SERVICE CLUBS HEAR ABOUT S. 1161

Dr. Harry V. Thomas, of Clarksburg, was the guest speaker at a joint meeting of the Kiwanis, Rotary, and Lions clubs, of Morgantown, held at the Hotel Morgan in that city, December 2. He spoke on the subject of socialized medicine, with particular reference to the Wagner-Murray bill now pending in Congress.

General News

1944 STANDING COMMITTEES NAMED FOR STATE MEDICAL ASSOCIATION

Dr. Robert J. Reed, Jr., president of the State Medical Association, has announced the appointment of Association committees for 1944. The committees on Child Welfare and Maternal Welfare were elected by the House of Delegates at the meeting held at Charleston last May. The chairman of each of these committees was heretofore appointed by the president-elect.

The members of the Publication Committee are always elected by the House of Delegates, and the new president, according to custom, appointed the Committee on Scientific Work the last day of the annual meeting at Charleston last year. The personnel of these committees is listed in the roster that is printed each month in the JOURNAL.

The following is a complete list of the members of the standing committees appointed by Doctor Reed for 1944:

Committees

Committee on Cancer: J. Ross Hunter, Charleston, chairman; Russell B. Bailey, Wheeling; Chauncey B. Wright, Huntington; J. E. Offner, Charleston; H. H. Haynes, Clarksburg; and Hu Myers, Philippi.

D. P. A. Advisory Committee: Hugh Bailey, Charleston, chairman; T. G. Reed, Charleston; and T. H. Blake, St. Albans.

Fact Finding and Planning Committee: Ray M. Bobbitt, Huntington, chairman; D. A. MacGregor, Wheeling; R. O. Rogers, Bluefield; T. L. Harris, Parkersburg; Carl E. Johnson, Morgantown; Frank V. Langfitt, Clarksburg; G. G. Irwin, Charleston; E. A. Trinkle, Weston; and G. O. Martin, Martinsburg.

Committee on Industrial Health: E. F. Gott, Charleston, chairman; E. N. Pell, Wheeling; Max Oates, Martinsburg; Walter E. Brewer, Logan; W. F. Rogers, Parkersburg; and J. M. Cofer, Bergoo.

Committee on Inter-Professional Relations: M. B. Williams, Wheeling, chairman; J. B. Clinton, Fairmont; C. T. Thompson, Morgantown; A. C. Lewis, Seth; and Thomas Bess, Keyser.

Committee on Legislation: R. O. Rogers, Bluefield, chairman; Frank V. Langfitt, Clarksburg; Ray M. Bobbitt, Huntington; George P. Evans, laeger; and George F. Grisinger, Charleston.

Committee on Medical Economics: R. V. Shanklin, Gary, chairman; John P. Helmick, Fairmont; G. P. Morison, Charles Town; Wm. C. D. McCuskey, Wheeling; and J. P. McMullen, Wellsburg.

Committee on Medical Education: R. J. Wilkinson, Huntington, chairman; Frank V. Langfitt, Clarksburg; E. J. Van Liere, Morgantown; Andrew E. Amick, Charleston; and Frank J. Holroyd, Princeton.

Committee on Necrology: James R. Bloss, Huntington, chairman; H. R. Johnson, Fairmont; and Chester Ogden, Clarksburg.

Committee on Publicity: James L. Wade, Parkersburg, chairman; W. W. Point, Charleston; and C. O. Post, Clarksburg.

Committee on Syphilis: Carl A. Hoffman, Huntington, chairman; Howard T. Phillips, Wheeling; L. E. Neal, Clarksburg; and M. L. Bonar, Charleston.

Committee on Conservation of Vision: Ivan Fawcett, Wheeling, chairman; R. A. Tomassene, Wheeling; V. E. Holcombe, Charleston; and Harry V. Thomas, Clarksburg.

PLANNING COMMITTEE FOR 1944

A fact finding and planning committee for 1944 has been named by Dr. Robert J. Reed, Jr., president of the State Medical Association. This special committee was first set up a few months ago by Dr. R. J. Wilkinson with the approval of the Council. The personnel of the committee named by Dr. Reed is as follows:

Ray M. Bobbitt, Huntington, chairman; D. A. MacGregor, Wheeling; R. O. Rogers, Bluefield; T. L. Harris, Parkersburg; Carl E. Johnson, Morgantown; Frank V. Langfitt, Clarksburg; G. G. Irwin, Charleston; E. A. Trinkle, Weston, and G. O. Martin, Martinsburg.

ROOM RESERVATIONS AT WHEELING

Reservations for rooms for the 77th annual meeting of the State Medical Association at Wheeling, May 15-16, 1944, are now being accepted at the Windsor and McLure hotels. Both have been designated as convention hotels, although scientific sessions will be held at the Windsor and commercial and scientific exhibits will be set up there.

It is important that reservations be made as soon as possible, for hotel rooms in Wheeling, as in other West Virginia cities, are always at a premium. A sufficient number of rooms have been arranged for to provide accommodations for the more than 300 doctors who are expected to attend the convention.

CENTRAL STATE COMMITTEE RENAMED

One of the first acts of Dr. Robert J. Reed, Jr., of Wheeling, the new president of the West Virginia State Medical Association, was to reappoint the members of the Central State Committee, heretofore named by Dr. R. J. Wilkinson, to cooperate with the advisory committees of component societies and representatives of group hospital service plans in matters pertaining to the organization of prepayment medical-surgical plans in West Virginia. The committee is composed of Dr. Ray M. Bobbitt, of Huntington, chairman; Dr. D. A. MacGregor, of Wheeling; and, Dr. R. O. Rogers, of Bluefield.

NEARLY 2,500 CASES APPROVED UNDER NEW STATE EMIC PROGRAM

Under the new Emergency Maternity and Infant Care program for the families of service men, 2,446 cases have been approved by the Division of Maternal and Child Hygiene of the State Health Department up to December 1, 1943, according to figures compiled by Dr. Lenore Patrick Chipman, director of the division. The amount authorized for expenditure since the program was initiated last May totals $196,961.

The number of doctors qualifying for this work now totals 560, and 11 osteopathic physicians and one midwife are also participating. Under the plan, sixty West Virginia hospitals have been approved for this type of work.

The following questions and answers have been prepared by Dr. Chipman for the information of doctors in West Virginia who are participating or who may desire to participate in the program:

The New EMIC Program

1. What patients are eligible for care under this program?

A.—Any pregnant woman whose husband is in the armed forces of the United States of the fourth, fifth, sixth, or seventh pay grades (sergeant, corporal, and private, or similar rank in the Navy, Marine Corps, or Coast Guard) who applies with her physician for medical care during pregnancy or within twenty-four hours after delivery. Applications should be sent promptly to the State Department of Health.

Similarly, any infant under one year of age whose father is listed in the pay grades above is eligible for medical, surgical, and hospital care.

2. How can the physician apply for this care?

A.—On the special blanks Form M for mother and Form M-1 for child sent out by the State Department of Health. On the application the mother gives the name of her husband, his rank, serial number, branch of service, and post office address.

3. If a doctor does not have one of the special State Health Department blanks, how may he apply in case of an emergency?

A.—The doctor should write a letter to the State Department of Health concerning the case, and request will be considered pending completion of the form later.

4. From what date does the State Department of Health begin to pay for professional services?

A.—The State Department of Health pays for services on and including the day the doctor and patient fill in the application form, and for emergency cases during the period when authorization is pending.

5. When should the physician apply for care given to pediatric cases?

A.—As soon as possible after the patient comes under his care. Authorization for pediatric care can only be made retroactive to cover the care rendered during the first week of illness while authorization was pending.

6. When will the physician be paid for services rendered to a maternity case?

A.—At the end of the six weeks postpartum period, the physician should send to the State Department of Health his report on the blank supplied to him when the case was authorized. As soon as the report is reviewed at the State Department of Health, a check will be sent to the physician; this generally takes about two weeks from the time the doctor sends the report.

7. When will the physician be paid for services given to pediatric cases?

A.—As soon as care is completed for an infant, and for all infant cases at the end of the first three weeks of illness, a report should be sent to the State Department of Health. Payments will be made as for maternity cases.

8. Is a blood serological test required for the detection of syphilis on maternity cases given care under the EMIC program?

A.—Yes, as early as possible during the prenatal period. For cases seen first during labor, a blood test on the mother must be taken before the final report is sent to the State Department of Health.

9. When was care under the EMIC program available to wives and sick infants of service men in pay grades one, two or three?

A.—On July 12, 1943 congress made available this service to the higher ranks of non-commissioned enlisted men wherever the woman would certify that there was a financial need for this care; on September 28, 1943 this provision was repealed, and as of October 1, 1943 the service was limited to families of service men in pay grades 1, 4, 5, 6, and 7.

Each month there will be more information concerning the EMIC program. It is important that all participating physicians read the information booklet on this program. The same information is in the June and September issues of the JOURNAL.

NEW ROSTER OF MEMBERS

The 1944 roster which is printed in this issue of the JOURNAL includes the names of all the members of the West Virginia State Medical Association as shown on the records at the headquarters office in Charleston. If any errors are found in the list, either in name or symbol designating honorary membership or signifying military service, they should be reported not later than January 15. At that time the roster will be finally corrected and printed in pamphlet form for distribution to Association and component society officers and JOURNAL advertisers.

MAJOR JOE SAVAGE MOVES

Major Joe W. Savage, commandant of cadets at the army air field at Hondo, Texas, since the summer of 1942, is now serving as Wing Adjutant of the 80th Flying Training Wing, recently activated and in charge of air navigation training at schools located at Hondo, San Marcos and Houston, Texas, and at Monroe, Louisiana, and Coral Gables, Florida. Headquarters will be maintained at San Marcos.

DR. OFFNER RECUPERATING

Dr. J. E. Offner, state health commissioner, who underwent an operation at Clarksburg the latter part of November, is now recuperating in a hospital in that city and expects to be able to resume his duties at Charleston shortly after the first of the year.

RELOCATIONS

Dr. J. M. Coram, of Beckley, has resigned as director of the Raleigh County Health Department and has relocated for the practice of his profession at Edwight.

* * * *

Dr. Don V. Hatton, former county health officer for Fayette county, is now attached to the staff of Williamson Memorial Hospital, at Williamson. Dr. J. E. Coleman, of Fayetteville, succeeds Dr. Hatton as county health officer.

* * * *

Dr. Edgar G. Miller, of Baltimore, has located at Weirton.

* * * *

Dr. S. A. Ford, who has been located at Edwight for several years, has moved to Beckley.

* * * *

Dr. E. M. Bond, of Amherstdale, has moved to Louisville, Kentucky, where he has accepted a position on the medical staff of the Curtiss-Wright Corporation.

ANNUAL FORUM ON ALLERGY

The Sixth Annual Forum on Allergy will be held at the Hotel Statler, St. Louis, January 22-23, 1944. The meeting, to which all reputable physicians are invited, provides opportunity for doctors to bring themselves up to date in this rapidly advancing branch of medicine. Almost every type of instructional method will be employed and special lectures will be delivered by outstanding authorities on allergy.

AMERICAN BOARD OF OPHTHALMOLOGY

The 1944 examinations of the American Board of Ophthalmology will be held at New York, January 3-4, 1944, and at Chicago, October 5-7, 1944. The executive office of the board has been moved to Portland, Maine, and the address is P. O. Box 1940, Post 21, Zone 2.

CONVENTION COMMITTEES APPOINTED

Dr. Hu Myers, of Philippi, has been named by Dr. Robert J. Reed, Jr., president of the West Virginia State Medical Association, as chairman of the Committee on Scientific Exhibit for the 77th annual meeting to be held at Wheeling, May 15-16, 1944. Dr. John P. Helmick, of Fairmont, and Dr. Fred R. Whittlesey, of Morgantown, were named members of the committee.

All scientific exhibits will be set up in the sun room just off the lobby at the Windsor Hotel. The committee has extended an open invitation to all doctors and institutions in West Virginia to arrange for exhibit space. There will apparently be no lack of space, and applications should be filed with Dr. Myers without delay.

Dr. M. B. Williams, of Wheeling, is chairman of the local committee on general arrangements. Besides Dr. Williams, the committee is composed of Drs. William McCuskey, Russell Bond, Howard Phillips, Russell Bailey, D. E. Greeneltch, Charles H. Clovis, Edward Pell, and Ivan Fawcett.

DOCTORS LICENSED BY PHC

The examinations for licensure conducted by the Public Health Council at Charleston, October 25-27, 1943, resulted in ten applicants being licensed to practice medicine in West Virginia, one by examination and nine by reciprocity.

Dr. George Miyakawa, of Charleston, was licensed by examination, and the following by reciprocity: Charles S. Clay, Huntington; Otis H. Coontz, Gary; Elizabeth Yahl Kuffner, Point Pleasant; Claude S. Lawson, Jr., Fairmont; Clarence A. Norberg, Caretta; William F. Pohl, Stirrat; Charles D. Hershey, Wheeling; Charles S. McKinley, Charleston; and, John S. Liggett, Wheeling.

PHC MEETS EARLY IN JANUARY

A meeting of the Public Health Council of West Virginia will be held at Charleston, January 3-5, 1944, for the purpose of examining applicants for license, both by reciprocity and examination. The meeting was set for this date in advance of the regular meeting date of the council in order that interns who complete nine months' service in hospitals may have the opportunity to take the examination before being called to active service in the medical corps of our armed forces.

A. P. O. AND FLEET P. O. ADDRESSES

Additional Army and Fleet Post Office addresses of West Virginia doctors in the military service have been received, as follows:

Lt. James E. McClung, MC.
APO 12472-A.
% Postmaster, New York, N. Y.

Capt. Louis Y. Peskoe, MC.
APO 7357.
% Postmaster, New York, N. Y.

Maj. Clarence I. Butte, Jr., MC.
APO 511.
% Postmaster, New York, N. Y.

Lt. Wm. E. McIlvain, MC. USNR.
% F. P. O., Navy 147.
New York, N. Y.

Lt. C. L. Houck, MC.
APO 429.
% Postmaster, New York, N. Y.

Capt. John W. Hash, MC.
APO 629.
% Postmaster, New York, N. Y.

Maj. Pat A. Tuckwiller, MC.
APO 9302.
% Postmaster, New York, N. Y.

Lt. Col. Robt. H. Jones, MC.
APO 782.
% Postmaster, New York, N. Y.

Capt. James L. Hager, MC.
APO 928.
% Postmaster, San Francisco, Calif.

Capt. Herbert N. Shanes, MC.
APO 9191.
% Postmaster, New York, N. Y.

Capt. Harry E. Baldock, MC.
APO 680.
% Postmaster, New York, N. Y.

Capt. Jacob C. Huffman, MC.
APO 9302.
% Postmaster, New York, N. Y.

Capt. John C. Condry, MC.
APO 813.
% Postmaster, New York, N. Y.

Maj. J. C. Ford, MC.
APO 837.
% Postmaster, New Orleans, La.

Capt. H. H. Golz, MC.
APO 782.
% Postmaster, New York, N. Y.

Capt. Wm. P. Bradford, MC.
APO 9301.
% Postmaster, New York, N. Y.

Lt. L. B. Gang, MC. USNR.
F. P. O., Navy 169.
New York, N. Y.

Capt. Ralph J. Jones, Jr., MC.
APO 730.
% Postmaster, Seattle, Wash.

Major Leonard N. Strickland, MC.
APO 302.
% Postmaster, New York, N. Y.

Col. C. F. Fisher, MC.
APO 782.
% Postmaster, New York, N. Y.

NURSE PRISONER OF JAPS

The first letter to be received from Lt. Ruby G. Bradley, West Virginia nurse with the Army Nurses Corps, since it was first ascertained that she was a prisoner of the Japanese, was received late in November by her father, F. O. Bradley, of Spencer. The letter was written in August and mailed from Manila in September.

Lieutenant Bradley, who was stationed at Walter Reed Hospital, Washington, before being sent to the Philippines in 1939, was acting chief nurse at Camp John Hay, Baguio, Philippine Islands, at the outbreak of the war. She was graduated from Philadelphia General Hospital in 1933 and enlisted in the Army Nurses Corps in 1935.

The letter is written from a civilian internment camp in the Philippines, and Lt. Bradley reports that they had been moved from Camp John Hay to Holmes. She continues: "The view of the mountains is grand, weather cool and general conditions good. I hope that you are not too worried about me. I am in good health, have had no illness, and weigh 110 pounds. Life here is not too dull, I work in the hospital, have reknit my sweaters, do a little cooking, reading, and my own laundry.

"I have enough food, and enjoy sleeping in a good bed. The people here have been very good to me, and I do appreciate their kindness. * * * Please tell Mrs. Flippe that Miss Chambers and I are here, and that Miss Davison and 64 nurses are in Manila. All are well as far as I know. Write me through the International Red Cross, Switzerland. I certainly appreciate this first opportunity to write."

CABELL COUNTY REJECTS PLAN

The Cabell County Medical Society has defeated by a margin of but two votes a proposal that the society sponsor a prepaid medical-surgical plan for Cabell County, to be administered by the local hospital service plan association. The vote was taken at a special meeting held December 14, after the medical service features had been stricken from the proposed contract, which was fashioned after the basic contract approved for use of component societies by a committee composed of members of the Fact Finding and Planning Committee of the State Medical Association.

No steps have yet been taken to amend the plan for resubmission to the society, but it has been indicated by some of the members that if objectionable features of the contract can be eliminated, the plan might possibly be resubmitted some time after the first of the year.

The society unanimously recommended that a full time county and city health unit be set up in Huntington, and that all the health activities of Cabell County be integrated. At the present time a part time unit is operating in that city.

NEW SUPERINTENDENT AT WELCH

Dr. J. C. Hutchinson, of Welch, has been appointed by Governor M. M. Neely as acting superintendent of the Welch Emergency Hospital. He succeeds Dr. F. E. LaPrade, who is undergoing treatment at Pinecrest Sanitarium, Beckley.

LESS CANCER IN PARENTS

Parents are less liable to death from cancer than other people. Harold Dorn states (in Human Biology) that for both men and women, those who marry and have children are less likely to die from cancer than those who remain single, but those who marry and have no children have the highest death rate from cancer.

While the difference in the death rate for men was not so marked, the mortality indices for married, widowed or divorced, and single women for England and Wales were 100, 117, and 105.

Statistics compiled from records in England, Wales and Australia show that childbearing decreases the likelihood of development of breast cancer, but increases the chances of cancer of the genital organs for woman. — *Science News Letter.*

THE TIME IS NOW

The time has come * * * for plain speech, for bold thinking and for decisive action. Bureaucratic control of medicine in starkest form, with all its obscene implications for the future of medical art and science is an imminent probability.

Let it now be clearly emphasized that in opposing the injection of political control into the administration of medical service, doctors do not imply any complacent toleration of the status quo. The record on that is clear. No other profession or calling has more radically and continuously improved the content and methods of its service than medicine, during the past half century.—*Westchester Medical Bulletin.*

WITH DOCTORS IN THE SERVICE

Major Leonard N. Strickland, of Widen, was promoted to the rank of major late in September. He is now serving with the 5th Army in Italy.

* * * *

Major J. C. Ford, of Huntington, is now serving as executive officer at a general hospital located overseas.

* * * *

Dr. R. J. Condry, of Elkins, who was recently promoted to the rank of commander, USNR, is now located in Ireland. He was formerly stationed in England and in Scotland. He writes that he has seen several West Virginians during his stay in the British Isles. He further says that the people of that country have been exceedingly cooperative and have done everything possible to make them comfortable.

* * * *

The Legion of Merit has been awarded by the Commander of the United States Naval Forces, Northwest African Waters, to Lieut. George M. Caldwell, (MC) USNR, of White Sulphur Springs, for exceptionally meritorious conduct as medical officer on the *U. S. S. Shubrick* during the Sicilian campaign. The citation is as follows:

"When the *U. S. S. Shubrick* was struck by an enemy bomb on August 4, 1943, in the harbor of Palermo, Sicily the ship was badly damaged with loss of all light and ventilation. Lieutenant Caldwell, with great coolness and professional skill, administered medical attention to the many critically wounded. His foresight and competence in preparation for handling casualties under battle conditions, minimized the loss of life in this engagement.

"The extraordinary ability and outstanding devotion to duty displayed by Lieutenant Caldwell reflected great credit upon himself and the naval service."

Lieutenant Caldwell, who is now stationed with the Navy V-12 Unit at the University of Louisville, writes that "your section on doctors in the service seems to be quite popular. It is certainly a favorite of mine. The JOURNAL has reached me fairly regularly and has been a source of interest, pleasure and inspiration."

* * * *

Capt. Ralph J. Jones, of Charleston, who is somewhere in the Pacific, writes that the August and September issues of the JOURNAL were finally received.

"The other day," he says, "one of my associates, a Major, MC, from Delaware, asked me if I knew about the 'Cannawaw' Valley. My reply was in the negative, until he told me it was in West Virginia. He had just been reading the article in a late issue of the *Satevepost*. The word is getting around, it seems.

"I am sorry that I cannot tell you more about what goes on here. I am not permitted to say anything about my present station except that it is somewhere in the Pacific. That narrows it down to not more than half the world's surface, and should consequently give you a very good idea of what it's like here."

* * * *

Major James L. Hager, of Charleston, writes that when he first arrived in Australia he assisted in setting up a number of dispensaries for field troops, serving as medical supply officer. "It is very interesting," he says, "to see how the Army takes care of emergencies in the field, and most of us doctors are amazed at the efficiency of the army methods."

Medical group near hospital train. Major Hager is shown at extreme left.

While on detached duty, Major Hager activated the first hospital train in his area. He equipped the train with modern thermostats for keeping food warm, and installed electric refrigerators and various other devices to add to the comfort of patients on long journeys.

Major Hager is now chief of the surgical service at a station hospital somewhere in the Southwest Pacific. "This is a beautiful land," he says, "and even in war times such as now one feels the enchantment of the tropical islands."

* * * *

Capt. Julian R. Kaufman, of Charleston, now

stationed at Camp Rucker, Alabama, has been made a diplomate of the American Board of Internal Medicine. He writes that three West Virginia doctors, Lieut. L. J. Pace, of Princeton; Capt. L. Y. Peskoe, of Boomer, and Dr. Dan Glassman, of Charleston, were with him for a short time but are now overseas.

* * * *

Captain Harry E. Baldock, of Charleston, is still in Iran, but has been transferred to the medical service of a large general hospital. He writes that it is a much larger hospital than the one to which he was formerly attached. He states that he is kept very busy, and is really doing more medicine than he has ever done before in the army.

* * * *

Major Lloyd R. Ayers, of Beckley, who has been stationed at Morris Field, N. C., is now attached to the 74th Tac. Rcn. Gp., Campbell Army Air Field, Camp Campbell, Kentucky.

* * * *

Captain Arkie B. Bowyer, of Elkview, has been located recently in North Africa, and now writes that he is in Italy. He says he is kept quite busy attending to his many duties. "The weather right now is wet," he writes, "but is unusually mild. We are living in tents out in a big pasture field—a swell place for a hospital when it rains!"

* * * *

Doctor Carl B. Hall, of Red Jacket, who is attached to the medical training section at Robins Field, Warner Robins, Ga., has recently been promoted to the rank of captain.

* * * *

Lieut. R. N. O'Dell, of Belle, is now serving as flight surgeon with a fighter squadron stationed in England.

* * * *

Captain John W. Hash, MC, of Charleston, writes from India under date of November 8, as follows:

"Today I received the August issue of the JOURNAL, so you see mail does get to us in India after so long a time. Any mail, no matter what the type or source, is always quite welcome.

"Our hospital is located on a tea plantation. We live in a planter's bungalow, which is surrounded by the most beautiful lawn and flower garden I have seen in India. The grounds provide ample space for the jackals and an occasional tiger to romp through. Up to this time we have not had any elephant visitors, but we do see them sometimes.

"Here's one for Ripley: We have a very strange bird on the grounds that whistles perfectly the first bar of 'Mister Saturday Night.'

"Major Chandler is quite busy these days doing eye surgery. We both send our best regards to all our friends back home. Best of luck in your efforts to defeat the Wagner-Murray bill."

* * * *

Dr. Walter E. Vest, Jr., of Huntington, who is assigned to the Station Hospital at Camp Chafee, Fort Smith, Ark., has recently been promoted to the rank of captain.

* * * *

Major C. Sherrill Rife, son of Dr. J. W. Rife, of Kenova, is attached to a 5th Army evacuation hospital in Italy.

* * * *

Lt. (jg) Uel C. Lovejoy, MC, USNR, who is serving with the marines in the Southwest Pacific, has written another interesting letter, dated November 19, in which he says that he has been ill with malaria, but has had a rapid recovery.

"Almost everyone out here," he writes, "has malaria in spite of all our malaria control and daily atabrine. We have moved our camp during the past two weeks from one cocoanut plantation to another. All of the islands have these plantations, and during a strong breeze it literally rains cocoanuts. Some of the marines have been hit on the head but suffered no serious injury.

"I had a letter from Dr. R. L. Calvert of Chelyan who is in England and he says that he has met some of our classmates, Lt. E. Norval Carter, of Huntington, and Dr. Pennington, who, with his wife, interned at St. Francis Hospital, Charleston, 1937-38."

* * * *

Lt. Col. Sobisca S. Hall, of Clarksburg, writes from the Air Corps Technical School, at Keesler Field, Mississippi, as follows:

"I enjoy the JOURNAL very much—all of it—but especially that portion dealing with the boys and our nurses in the service. Keep it up, for it is a needed liaison with the past, and an assurance of reunion when Hitler and Hirohito are finished."

* * * *

Dr. Joe N. Jarrett, of Oak Hill, who is assigned to the Medical and Psychological Examining Unit, AAF, in Miami Beach, has recently been promoted to the rank of captain. He is in charge of the general physical examination section of the unit.

* * * *

Major Howard A. Swart, of Charleston, who has finished his initial training at Carlisle Barracks, Pennsylvania, is now attached to the staff of the

Newton D. Baker General Hospital, at Martinsburg.

* * * *

Major M. H. Bertling, of Bluefield, is now assigned to the Reception Center at Camp Wolters, Texas.

* * * *

Major Francis C. Prunty, son of Dr. S. M. Prunty, of Parkersburg, who is assigned to the United States Army Air Forces, at Kerns Field, Utah, as chief of the Division of Dermatology and Syphilology, was made a diplomate of the American Board of Dermatology and Syphilology at the annual meeting in Philadelphia in November.

* * * *

Lieut. Charles M. Polan, of Huntington, who is attached to the Station Hospital at Camp Luna, Las Vegas, New Mexico, was recently certified by the American Board of Ophthalmology. He took the examination at Chicago in October.

* * * *

Major Arnold Wilson, of Welch, writes from England that, "we are so scarce of paper that we conserve in every way possible. We use envelopes over and over again by pasting a new address on an old address." He says that he had just received a copy of the JOURNAL, but adds that before he could look at it, "the West Virginia nurses took it away from me to read the 'Doctors in the Service' page. They read in this copy that Dr. Claude Smith is now a major and found many other names that were familiar.

"Three of the nurses who ganged up on me," he says, "were Miss Eaton and Miss Sergeant, of Charleston, and Miss Wilbur, of Beckley. All send their best regards."

CZAR OF MEDICINE PROPOSED

The Wagner-Murray Bill has been introduced in the Senate. It is the American Beveridge Plan—"from the cradle to the grave." Its passage would doom the practice of medicine as we have known it. It would place almost unlimited control of the profession in the hands of one man—the Surgeon General of the Public Health Service. It must not pass! Not because of any selfish interest on our part, but for the good of the health of all the people. An enslaved physician cannot adequately serve the people.—James Stevenson, M. D., in *Journal of the Oklahoma State Medical Association.*

Obituaries

JESSE MALOY, M. D.

Dr. Jesse S. Maloy, of Shinnston, was born March 12, 1873, at McDowell, Virginia. He received his early education at Shenandoah Normal School, and graduated from the Medical College of Virginia in 1898. He was licensed in West Virginia the same year, and located for the practice of his profession in Harrison County. He had always been active in the affairs of his county medical society and had served as its president. He was a member of the West Virginia State Medical Association and the American Medical Association. Doctor Maloy died November 21, 1943 of carcinoma.

BENJAMIN O. ROBINSON, M. D.

Dr. Benjamin O. Robinson, of Parkersburg, was born at Lubeck, Wood County, March 5, 1879. He received his M. D. degree at Maryland University in 1904. At the completion of his internship in a hospital at Parkersburg, he served as resident at Mercy Hospital, Baltimore in 1906, and completed a postgraduate course at the New York Postgraduate Hospital in 1908. That same year he was licensed to practice in West Virginia.

Dr. Robinson was a Fellow of the American College of Surgeons, had served a term as president of the Public Health Council of West Virginia, and for many years was coroner of Wood County. He was a member of the staffs of Camden-Clark Memorial and St. Joseph's hospitals. He was always active in the affairs of the Academy of Medicine of Parkersburg, and had served a term as its president.

Dr. Robinson died at his home at Parkersburg, October 4, 1943, of coronary thrombosis.

A. G. WILKINSON, M. D.

Dr. A. G. Wilkinson, 77, of Wayne, county health officer for Wayne county, was born in that city February 15, 1866. He was educated in the public schools and at Louisville Medical College, where he received his M. D. degree in 1893. He was licensed the following year in West Virginia and located at Wayne, where he continued in active practice until his death from heart disease November 29, 1943. He is survived by his widow, three daughters and two sons.

WEST VIRGINIA STATE MEDICAL ASSOCIATION

ROSTER OF MEMBERS BY SOCIETIES

(January 1, 1944)

BARBOUR-RANDOLPH-TUCKER

Ashworth, Glenn ... Philippi
Bolton, H. H. ... Hilliard (Fla.)
*Bosworth, J. L. ... Mill Creek
Butt, A. P. ... Elkins
‡Chenoweth, P. C. ... Elkins
‡Condry, R. J. ... Elkins
‡Conrad, H. A. ... Elkins
‡Euphrat, Edwin J. ... Elkins
Golden, B. I. ... Elkins
Goodwin, T. M. ... Elkins
Gray, P. L. ... Elkins
Hall, C. H. ... Elkins
*Hamilton, E. M. ... Belington
Harper, W. G. ... Elkins
Houston, Robt. A. ... Elkins
Huffman, Jacob F. ... Harmon
Jeffries, E. M. ... Philippi
‡King, L. S. ... Philippi
Levy, Fritz ... Elkins
Liggett, B. L. ... Mill Creek
‡Main, Emory H. ... Philippi
‡Martin, Joseph E. ... Elkins
Matheny, B. F. ... Parsons
Maxwell, M. H. ... Elkins
Michael, G. H. ... Parsons
Miller, J. L. ... Thomas
Moore, S. G. ... Harper's Ferry
Moyer, E. ... Norton
‡Murphy, Franklin B. ... Philippi
‡Myers, E. E. ... Philippi
Myers, H. C. ... Philippi
‡Myers, Junior ... Philippi
Myers, K. J. ... Philippi
Nefflen, L. H. ... Elkins
*Owens, H. K. ... Elkins
Parker, H. S. ... Thomas
‡Roberts, Donald R. ... Elkins
Skar, S. J. ... Davis
Small, Maurice J. ... Parsons
Smith, W. S. ... Philippi
Stroud, C. G. ... Brownton
Tabor, Jack H. ... Dailey
‡Weisman, S. ... Parsons
Whiteside, W. E. ... Parsons
Woodford, J. R. ... Philippi
‡Woodford, T. L. ... Belington
Wright, E. O. ... Galloway

BOONE

Aliff, Paul ... Nellis
‡Ballard, O. D. ... Van
Barbour, W. L. ... Whitesville
Calfee, W. R. ... Whitesville
Caylor, L. G. ... Highcoal
Gallup, Theo. ... Sharples
Glover, A. E. ... Madison
Harless, W. F. ... Madison
Hill, David H. ... Madison
Hunter, R. L. ... Madison
Lewis, A. C. ... Seth
Pauley, D. F. ... Jeffrey
Prather, F. G. ... Wharton
Wilkerson, W. V. ... Prenter

‡ In Military Service.
* Honorary Member.

BROOKE

‡Booher, W. T. ... Wellsburg
‡Hegner, H. L. ... Wellsburg
‡Jacob, S. S. ... Bethany
Matson, F. L. ... Wellsburg
Megahan, C. R. ... Follansbee
McGraw, Ralph ... Follansbee
McMullen, J. P. ... Wellsburg
Otte, R. C. ... Wellsburg
Palmer, J. B. ... Wellsburg

CABELL

Baber, J. H. ... Huntington
Ball, Evelyn ... Huntington
Barker, J. F. ... Huntington
‡Beard, H. E. ... Huntington
Beckner, W. F. ... Huntington
Biern, O. B. ... Huntington
Bloss, J. R. ... Huntington
Bobbitt, R. M. ... Huntington
‡Boso, Clarence H. ... Huntington
Bourn, W. D. ... Barboursville
Brandabur, J. J. ... Huntington
Brown, B. F. ... Huntington
Brown, F. A. ... Huntington
‡Brown, J. R. ... Huntington
*Bruns, W. F. ... Ceredo
‡Calvert, R. L. ... Chelyan
‡Carter, E. Norval ... Huntington
Chambers, V. L. ... Huntington
Christian, Leo ... Huntington
‡Claiborne, W. L. ... Huntington
‡Coffey, F. L. ... Huntington
‡Cook, J. R. ... Huntington
‡Coplin, Robt. W. ... Huntington
*Crews, A. W. ... Huntington
Cronin, D. J. ... Huntington
Curry, R. H. ... Barboursville
‡Daniels, W. F. ... Huntington
Dodson, Ross ... Huntington
‡Duncan, C. S. ... Huntington
Farnsworth, F. F. ... Milton
Ferguson, J. W. ... Kenova
Folsom, T. G. ... Huntington
Ford, C. P. S. ... Huntington
‡Ford, J. C. ... Huntington
‡Gang, L. B. ... Huntington
‡Garred, E. W. ... Milton
Garrett, B. D. ... Kenova
Genge, Cole D. ... Huntington
Gerlach, E. B. ... Huntington
Gibson, A. P. ... Huntington
Grimm, W. O. ... Huntington
Guthrie, J. A. ... Huntington
Hamilton, O. L. ... Huntington
Hardman, J. C. ... Huntington
Hardwick, R. ... Huntington
Harwood, I. R. ... Huntington
Hatfield, H. D. ... Huntington
Hawes, C. M. ... Huntington
Hayman, Douglas ... Huntington
Hayman, J. S. ... Huntington
*Hereford, W. D. ... Huntington
*Hicks, I. C. ... Huntington
Hines, N. F. ... Huntington
Hirschman, I. I. ... Huntington
Hodges, F. C. ... Huntington
Hoffman, C. A. ... Huntington
Hoitash, F. J. ... Huntington
Hubbard, J. E. ... Huntington
Humphrey, E. J. ... Huntington
‡Hunter, W. B. ... Huntington
Hutchison, J. L. ... Huntington
Irmen, F. A. ... Huntington
Jaskiewicz, C. F. ... Huntington
Johnson, G. D. ... Huntington
Jones, A. S. ... Huntington
Kappes, W. C. ... Huntington
Kessler, A. D. ... Huntington
*Kessler, A. K. ... Huntington
Ketchum, Dorsey ... Huntington
‡Klumpp, J. S. ... Huntington
Lusher, H. V. ... Huntington
‡Lyon, G. M. ... Huntington
*MacKenzie, A. R. ... Huntington
Marple, F. O. ... Huntington
‡Martin, W. B. ... Huntington
McClellan, G. O. ... West Hamlin
‡Meek, E. M. ... Huntington
Moore, Hallock ... Huntington
Moore, L. J. ... Huntington
Moore, M. B. ... Huntington
Moore, T. W. ... Huntington
Morrison, G. C. ... Huntington
‡Muller, H. E. ... Huntington
Neal, W. E. ... Huntington
‡Neal, W. L. ... Huntington
Parsons, W. J. ... Huntington
Plymale, Clarence ... Huntington
‡Polan, Chas. M. ... Huntington
Porter, W. J. ... Wayne
Ratcliff, G. A. ... Huntington
Reaser, E. F. ... Huntington
Reynolds, C. O. ... Huntington
Reynolds, Otis E. ... Huntington
Richmond, L. C. ... Milton
Rife, J. W. ... Kenova
Rowley, W. N. ... Huntington
Rutherford, A. G. ... Huntington
Schuller, F. X. ... Huntington
‡Scott, F. A. ... Huntington
Shafer, E. E. ... Huntington
Silver, Harry ... Milton
Sloan, R. M. ... Huntington
Steenbergen, J. H. ... Huntington
Stevens, Richard J. ... Huntington
Stotts, Roscoe ... Kenova
‡Strange, W. W. ... Huntington
Swann, W. C. ... Huntington
Taylor, C. T. ... Huntington
‡Taylor, Ewing ... Huntington
Taylor, I. W. ... Huntington
Van Metre, R. S. ... Huntington
Vest, W. E. ... Huntington
Walden, G. W. ... West Hamlin
‡Weinstein, Stanley ... Huntington
Wilkinson, R. J. ... Huntington
Willis, C. A. ... Huntington
Willis, C. G. ... Huntington
Wright, C. B. ... Huntington
Wylie, R. M. ... Huntington

CENTRAL WEST VIRGINIA

*Allen, S. P. ... Webster Springs
‡Bowyer, A. B. ... Elkview
Brown, E. S. ... Summersville
Brown, F. H. ... Summersville

Brown, H. S. ... Sutton
‡Carson, C. C. ... Gassaway
Cofer, J. M. ... Bergoo
Cutright, R. G. ... Buckhannon
Deeds, L. W. ... Buckhannon
Dodrill, J. B. ... Webster Springs
*Dunn, Hugh ... Richwood
Eakle, J. C. ... Sutton
Eakle, O. O. ... Sutton
‡Echols, J. E. ... Richwood
Echols, W. E. ... Richwood
‡Ferrell, R. M. ... Webster Springs
Fisher, E. L. ... Gassaway
Forman, Worth ... Buckhannon
‡Hartman, I. F. ... Buckhannon
Hill, G. D. ... Tioga
Hill, L. O. ... Camden-on-Gauley
‡Huffman, J. C. ... Buckhannon
Huffman, W. W. ... Webster Springs
Hunter, E. H. ... Webster Springs
*McCauley, W. H. ... Sutton
‡McClung, James E. ... Richwood
McClung, James ... Richwood
‡McClung, W. D. ... Richwood
Morrison, M. T. ... Sutton
Nelson, William ... Richwood
Page, B. L. ... Buckhannon
Peters, D. C. ... Richwood
Rusmisell, J. A. ... Buckhannon
‡Rusmisell, J. A., Jr. ... Buckhannon
Van Tromp, H. O. ... French Creek
*Walker, Everett ... Adrian

DODDRIDGE

Harper, F. G. ... West Union
Poole, A. ... West Union
White, R. S. ... West Union

EASTERN PANHANDLE

‡Armentrout, A. W. ... Martinsburg
Bitner, E. H. ... Martinsburg
Clapham, R. E. ... Martinsburg
Dupuy, H. R. ... Martinsburg
Eagle, A. B. ... Martinsburg
‡Fox, M. R. ... Charles Town
‡Glenn, Marshall ... Charles Town
Glover, V. L. ... Martinsburg
Guthrie, J. K. ... Martinsburg
‡Haltom, W. L. ... Martinsburg
Hendrix, N. B. ... Martinsburg
Link, Vaughn ... Shepherdstown
Martin, G. O. ... Martinsburg
McFetridge, Elizabeth ... Shepherdstown
Morison, G. P. ... Charles Town
Oates, Max ... Martinsburg
Oates, T. K. ... Martinsburg
‡Porterfield, M. H. ... Martinsburg
Power, C. G. ... Martinsburg
‡Shaw, D. J. ... Berkeley Springs
Talbott, R. B. ... Martinsburg
Tonkin, H. G. ... Martinsburg
Van Metre, J. L. ... Charles Town
‡Wallace, W. A. ... Martinsburg
Wanger, Halvard ... Shepherdstown
‡Warden, W. P. ... Charles Town
‡Waters, Z. J. ... Baltimore, (Md.)
Willard, E. H. ... Berkeley Springs

FAYETTE

Bays, A. E. ... Montgomery
‡Becker, Philip L. ... Kimberly
Bilger, F. W. ... McComas
Bittinger, W. P. ... Summerlee
Brugh, B. F. ... Montgomery
Bundy, W. E. ... Minden
‡Butterfield, D. L. ... Milburn
‡Cardey, N. L. ... Winona
Carter, Eugene S., Jr. ... Boomer
‡Crank, G. O. ... Lawton
Daugherty, T. B. ... Fayetteville
Davis, W. B. ... Rainelle
‡Dickerson, L. A. ... Fayetteville
Englefried, C. H. ... Charleston
‡Feldman, John L. ... Longacre
Frazier, Claude ... Winona
‡Friedman, Norman ... Longacre
Harless, L. R. ... Gauley Bridge
*Henderson, O. J. ... Montgomery
Higginbotham, Upshur ... Montgomery
Hodges, G. G. ... Mt. Hope
‡Hresan, M. G. ... Minden
Jackson, H. M. ... Fayetteville
‡Jarrett, J. N. ... Oak Hill
‡Jones, E. E., Jr. ... Mount Hope
King, W. E. ... Montgomery
Laird, T. K. ... Montgomery
Laird, W. R. ... Montgomery
‡Lamb, R. M. ... Winona
Martin, H. C. ... Rainelle
McGehee, M. W. ... Montgomery
Merriam, C. G. ... Page
Moore, M. A. ... Longacre
Moser, L. A. ... Minden
‡Nolan, L. E. ... Montgomery
Nutter, E. V. ... Gauley Bridge
Peck, R. S. ... Cannelton
‡Peskoe, L. Y. ... Boomer
Pope, Thos. B. ... Kingston
Prillaman, P. E. ... Scarbro
Puckett, B. F. ... Oak Hill
Reeves, J. N. ... Oak Hill
Roark, J. L. ... Kimberly
*Shaffer, J. S. ... Montgomery
*Shirkey, D. W. ... Montgomery
Skaggs, H. C. ... Montgomery
Smith, G. A. ... Montgomery
Stallard, C. W. ... Montgomery
Thompson, E. B. ... Montgomery
Thompson, J. B. ... Oak Hill
‡Updike, R. A. ... Montgomery
Watkins, C. E. ... Harvey

GREENBRIER VALLEY

‡Caldwell, Geo. M. ... White Sulphur Springs
Cecil, R. C. ... Richmond, (Va.)
Compton, J. W. ... Ronceverte
Crawley, J. R. ... Anjean
Duncan, Herbert ... Lewisburg
Ferrell, A. D. ... Ronceverte
Goodman, H. L. ... Ronceverte
Gunning, H. D. ... Ronceverte
Hamrick, K. J. ... Marlinton
*Hinsdale, Guy ... Charlottesville, (Va.)
Jackson, C. C. ... East Rainelle
*Kirkpatrick, H. L. ... White Sulphur Springs
Lanham, A. G. ... Ronceverte
Leech, J. G. ... Quinwood
Lemon, C. W. ... Lewisburg
Mahood, C. F. ... Alderson
‡Mamick, Stephen ... White Sulphur Springs
Matney, T. G. ... Lindside
‡McCauley, E. W. ... Rainelle
McClintic, C. F. ... Williamsburg
McFerrin, S. A. ... Renick
Mitchell, D. W. ... Ronceverte
Myles, W. E. ... White Sulphur Springs
Preston, D. G. ... Lewisburg
‡Todd, L. B. ... Quinwood
Von Bose, Edda ... Philadelphia, (Pa.)
Wall, C. I. ... Rainelle
Williams, L. ... Beelick Knob

HANCOCK

‡Beaumont, G. L. ... New Cumberland
Bogarad, M. ... Weirton
‡Boggs, Edward H. ... Hinton
‡Brand, J. M. ... Chester
‡Bruce, T. H. ... New Cumberland
Fisher, J. E. ... New Cumberland
Focer, R. L. ... Weirton
‡McNinch, E. R. ... Weirton
‡Moore, B. J. ... Chester
‡Polen, F. E. ... Hollidays Cove
Powers, M. H. ... Weirton
‡Prioletti, V. ... Weirton
Richmond, J. E. ... Weirton
Rigas, George ... Weirton
Rinehart, A. B. ... Weirton
Schwartz, L. O. ... Weirton
Slate, T. A. ... Hollidays Cove
Thompson, J. L. ... Weirton
Whitaker, L. A. ... Weirton
Wolpert, Milton ... Chester
‡Yurko, Anthony ... Hollidays Cove

HARRISON

‡Allman, W. H. ... Clarksburg
Brake, B. S. ... Clarksburg
Brannon, E. H. ... Bridgeport
Brennan, J. T. ... Clarksburg
Carder, J. R. ... Clarksburg
Chandler, F. C. ... Bridgeport
Coffindaffer, R. S. ... Shinnston
Cruikshank, D. P. ... Lumberport
Davis, Edward ... Salem
Davis, W. M. ... Bridgeport
*Esker, H. H. ... Clarksburg
‡Evans, G. F. ... Clarksburg
‡Ferrell, Marcus E. ... Clarksburg
‡Fisher, C. F. ... Clarksburg
Flowers, Earl N. ... Clarksburg
*Flowers, Edward Newton ... Clarksburg
*Folk, John ... Bridgeport
‡Genin, F. G. ... Clarksburg
‡Gilman, Joseph ... Clarksburg
Gocke, Thomas ... Clarksburg
Gocke, W. T. ... Clarksburg
‡Golz, H. H. ... Clarksburg
Grant, Sylvia ... Bridgeport
Greer, C. C. ... Clarksburg
‡Hall, S. S. ... Clarksburg
Hanifan, R. K. ... Clarksburg
Harris, T. G. ... West Milford
Haynes, H. H. ... Clarksburg
‡Hess, D. S. ... Shinnston
*Hill, E. A. ... Clarksburg
Hodge, Ben E. ... Clarksburg
*Hood, T. M. ... Clarksburg
‡Humphries, R. T. ... Clarksburg
Jackson, Kenna ... Clarksburg
Jarvis, C. C. ... Clarksburg
Kelly, A. O. ... Wallace
Kemper, A. J. ... Lost Creek
Kerr, John C. ... Clarksburg
Ladwig, O. W. ... Wilsonburg
Langfitt, F. V. ... Clarksburg
Lembright, J. F. ... Clarksburg
Linger, R. B. ... Clarksburg
Lough, D. H. ... Clarksburg
Lynch, R. V. ... Meadowbrook
‡McCuskey, John F. ... Clarksburg
McGuire, J. P. ... Clarksburg

‡ In Military Service.
* Honorary Member.

Mills, L. H. ... Clarksburg
Neal, L. E. ... Clarksburg
‡Nutter, Paul J. ... Clarksburg
‡Nutter, R. B., Jr. ... Lumberport
Nutter, R. J. ... Clarksburg
*Ogden, C. R. ... Clarksburg
Owens, W. T. ... Clarksburg
Page, J. E. ... Clarksburg
*Pendleton, E. ... Clarksburg
Pletcher, R. O. ... Lost Creek
Post, A. T. ... Clarksburg
Post, C. O. ... Clarksburg
Post, S. H. ... Volga
‡Ralston, James ... Clarksburg
Repass, James ... Lumberport
‡Riheldaffer, Wm. H. ... Romney
*Riley, R. M. ... Nutter Fort
Rose, George W. ... Salem
Slater, C. N. ... Clarksburg
Sloan, H. E. ... Clarksburg
Spelsburg, W. W. ... Clarksburg
Stephenson, J. E. ... Clarksburg
Strother, W. L. ... Salem
Thomas, H. V. ... Clarksburg
Tucker, E. D. ... Nutter Fort
Waddell, R. L. ... Shinnston
‡Weaver, Andrew J. ... Clarksburg
*Wehner, E. F. ... Clarksburg
Whisler, H. A. ... Clarksburg
Wilkinson, B. W. ... Clarksburg
Williams, J. F., Jr. ... Clarksburg
Wilson, J. E. ... Clarksburg
‡Wilson, James E., Jr. ... Clarksburg
‡Wornal, L. S. ... Shinnston
Wright, E. B. ... Clarksburg
Wright, W. B. ... Clarksburg
‡Zinn, L. D. ... Clarksburg

KANAWHA

Albrecht, M. ... Charleston
Amick, A. E. ... Charleston
*Amick, A. L. ... Charleston
*Anderson, Maury ... Dunbar
Anderson, R. L. ... Charleston
Angell, H. W. ... Charleston
Angstadt, N. G. ... Charleston
‡Ashman, H. ... Gallagher
Baer, R. E. ... South Charleston
Bailey, H. A. ... Charleston
Bailey, R. W. ... Hurricane
‡Baldock, H. E. ... Charleston
Ball, Ernest ... Charleston
Banks, J. Bankhead ... Charleston
Barber, D. N. ... Charleston
Barber, T. M. ... Charleston
‡Basman, Jack ... Charleston
Baum, Henry ... Charleston
Beddow, H. M. ... Charleston
‡Bivens, S. L. ... Charleston
Black, W. P. ... Charleston
Blagg, B. V. ... South Charleston
Blake, T. H. ... St. Albans
Bobbitt, O. H. ... Charleston
‡Bolarsky, Julius ... Charleston
Bonar, M. L. ... Charleston
‡Bradford, Bert, Jr. ... Charleston
Brady, A. S., Jr. ... Charleston
‡Brick, John P. ... Charleston
Brown, H. M. ... Charleston
Brown, R. J. ... Charleston
Buff, I. E. ... Charleston
Buford, R. K. ... Charleston
Bull, S. W. ... Spencer

‡ In Military Service.
* Honorary Member.

Burdette, Rex A. ... Charleston
Cannaday, J. E. ... Charleston
Capito, G. B. ... Charleston
‡Carlson, F. B. ... Charleston
Champe, Preston ... Charleston
‡Chandler, A. C. ... Charleston
Chipman, Lenore Patrick ... Charleston
‡Churchman, V. T. ... Charleston
Clark, F. A. ... Charleston
‡Cooke, W. L. ... Charleston
*Copeland, C. E. ... Charleston
Cox, L. E. ... Charleston
Daniel, G. A. ... Belle
Davis, E. A. ... Charleston
‡Dawson, R. O. ... Charleston
DeBell, A. W. ... Malden
Dent, D. A. ... Charleston
Duling, M. S. ... Charleston
Dunlap, J. L. ... Nitro
Dunn, R. H. ... South Charleston
‡Eckmann, Leonard ... South Charleston
Elkin, W. P. ... Charleston
Erwin, F. L. ... Burnwell
‡Escue, H. M. ... Charleston
Eves, F. P. ... Charleston
Fisher, H. H. ... Dunbar
Frame, R. I. ... Sharples
Frank, Ludwig ... Charleston
Frazier, J. W. ... Charleston
Gerhardt, P. R. ... Charleston
‡Given, A. J. ... Rensford
Glass, H. R. ... Charleston
Glass, W. J. ... Sissonville
‡Glassman, Dan ... Charleston
‡Godbey, J. R. ... Charleston
Gordon, A. T. ... Spencer
Gott, Fred ... Charleston
‡Grace, J. E. ... Cabin Creek
Grisinger, G. F. ... Charleston
‡Groves, Owen A. ... Charleston
‡Hager, J. L. ... Charleston
‡Haley, John B. ... Charleston
‡Haley, P. A., II ... Charleston
Halloran, R. O. ... Charleston
Hamrick, R. E. ... Charleston
Hamrick, R. S. ... St. Albans
*Hansford, J. H. ... Pratt
Hardesty, W. L. ... Charleston
Harper, C. A. ... Clendenin
Harper, O. M. ... Clendenin
‡Hash, J. W. ... Charleston
Hayes, E. R. ... Chelyan
Heffner, G. P. ... Charleston
Henson, E. B. ... Charleston
‡Hill, H. M., Jr. ... Charleston
Hoffman, W. E. ... Charleston
Hoke, L. I. ... Nitro
Holcombe, V. E. ... Charleston
‡Houck, C. L. ... Carbon
Houck, M. R. ... Carbon
Howell, H. H. ... Madison
Hudgins, A. P. ... Charleston
Hunter, J. Ross ... Charleston
Hutchinson, T. H. ... Malden
Iatesta, Mathew ... Charleston
Ireland, R. A. ... Charleston
Irwin, G. G. ... Charleston
Jabaut, S. W. ... South Charleston
‡Jarrell, C. A. ... Belle
Jarrett, L. A. ... Dunbar
‡Jones, Ralph J. ... Charleston
‡Jordan, E. V. ... Charleston
‡Kaufman, J. R. ... Charleston
Kessel, C. R. ... Ripley
‡Kessel, Ray ... Charleston
‡Kessel, Russell ... Charleston
Ketchum, R. D. ... Charleston

Lampton, Arthur K. ... Charleston
Lance, V. L. ... Charleston
‡Laslie, J. C. ... Charleston
Law, H. D. ... Charleston
‡Lewis, C. E. ... Charleston
‡Lilly, Goff P. ... Charleston
Lilly, J. P. ... Charleston
Litton, A. C. ... Charleston
Litsinger, E. A. ... Charleston
Louft, R. R. ... Charleston
‡Lutz, John ... Charleston
Mace, V. E. ... Charleston
‡MacNamara, R. J. ... Charleston
‡Mantz, T. Paul ... Charleston
‡Marquis, J. N. ... Charleston
Marshall, C. B. ... Nitro
‡Matthews, L. B. ... Charleston
McClue, A. E. ... Dunbar
McClure, U. G. ... Charleston
McLaughlin, Ralph ... Charleston
*McMillan, W. A. ... Charleston
McMillan, W. O. ... Charleston
McPherson, H. D. ... Eskdale
Mendeloff, M. I. ... Charleston
Mican, H. M. ... Charleston
Milhoan, A. W. ... Nitro
Morison, O. N. ... Charleston
Mynes, L. H. ... Charleston
Nale, T. W. ... Charleston
‡Newhouse, N. H. ... Charleston
Niedermyer, J. W. ... Charleston
‡Palmer, G. F. ... Charleston
Peck, Earl M. ... Charleston
Pence, R. E. ... South Charleston
‡Peters, J. T. ... South Charleston
‡Peterson, V. L. ... Charleston
Point, W. W. ... Charleston
‡Pollock, B. H. ... Charleston
‡Polsue, W. C. ... Charleston
Powell, C. W. ... Charleston
Preiser, Phillip ... Charleston
‡Press, Edward W. ... Charleston
*Preston, B. S. ... Concord, (Tenn.)
Price, A. M. ... Charleston
Price, R. B. ... Charleston
‡Pushkin, Willard ... Charleston
Putschar, W. J. G. ... Charleston
Reed, T. G. ... Charleston
‡Reel, F. C. ... Charleston
‡Revercomb, P. H. ... Charleston
Ritter, H. H. ... Charleston
Robertson, G. C. ... Charleston
Robertson, H. L. ... Charelston
*Robertson, W. B. ... Kearneysville
Robertson, W. S. ... Charleston
Robins, J. E., Jr. ... Charleston
Robinson, J. H. ... Charleston
Rohr, J. U. ... Charleston
Rucker, J. E. ... Charleston
*Schoolfield, G. C. ... Charleston
Scott, C. N. ... Nitro
Seletz, Abraham ... Charleston
Selman, J. H. ... Charleston
‡Shamblen, Earle ... Charleston
Shawkey, A. A. ... Charleston
‡Shepherd, E. M. ... Charleston
Shepherd, W. S. ... Charleston
Shirkey, W. F. ... Charleston
Skaggs, J. S. ... Montcoal
Skaggs, J. W. ... Nitro
Smith, A. A. ... Clay
Smith, B. A. ... Spencer
‡Smith, C. B. ... Charleston
Smith, J. A. ... Sanford, (Fla.)
Souleyret, S. B. ... Coalburg
‡Soulsby, P. C. ... Pratt
Squire, E. W. ... Charleston

‡Staats, Charles — Charleston
*Staats, H. H. — Charleston
Stewart, W. C. — Charleston
‡Strickland, L. N. — Widen
Stork, A. R. — Charleston
‡Swart, H. A. — Charleston
Swint, B. H. — Charleston
‡Thomas, W. C. — Charleston
Thompson, H. G. — Charleston
‡Thornhill, W. A., Jr. — Charleston
‡Tuckwiller, P. A. — Charleston
Vaughan, E. O. — St. Albans
‡Ward, Harold W. — Sutton
Watts, C. N. — Charleston
Webb, R. L. — Charleston
Whiteside, C. T. — Kayford
Wilson, A. A. — Charleston
Wilson, W. B. — Charleston
*Wilson, W. H. — St. Albans
Woodall, R. E. — Charleston
Work, W. F. — Charleston

LEWIS

Andrew, H. M. — Weston
Burton, G. M. — Weston
Burton, S. H. — Weston
Cooper, E. R. — Weston
Corder, G. C. — Jane Lew
Fisher, R. M. — Weston
Ford, R. J. — Weston
Garrison, Harry A. — Weston
*Hall, E. T. W. — Weston
*Hudkins, O. L. — Weston
*Kessler, D. P. — Weston
*King, W. P. — Weston
Lawson, A. F. — Weston
Long, A. E. — Weston
Offner, J. E. — Weston
Rohr, C. B. — Alum Bridge
Smith, W. T. — Glenville
Snaith, Theresa — Weston
*Snyder, George — Weston
Stalnaker, Guy — Glenville
Trinkle, E. A. — Weston

LOGAN

Altizer, A. E. — Accoville
*Aultz, L. L. — Ward
‡Bonar, Robert R. — Whitman
‡Bond, Dewitt T. — Amherstdale
Bond, E. M. — Louisville, (Ky.)
‡Brammer, F. E. — Dehue
Brewer, W. E. — Logan
Brown, C. Leonard — Holden
Carney, J. W. — Logan
Combes, L. G. — Holden
Davis, C. A. — Logan
Deason, V. A. — Logan
Farley, H. H. — Logan
‡French, A. M. — Logan
Hamilton, W. P. — Logan
Hively, H. D. — Ward
Jamison, Frank — Dehue
Klausman, Wm. A. — Holden
‡Kruger, I. M. — Logan
Lawson, L. W. — Logan
*Lawson, S. B. — Logan
‡Layman, L. H. — Holden
‡Lovejoy, U. C. — Omar
Lyons, J. W. — Holden
Matthews, W. E. — Logan
McClellan, W. T. — Ethel
Millman, T. H. — Earling
‡Nelson, E. R. — Logan
Parker, W. H. — Braeholm
Patterson, J. L. — Holden
Poling, Owen — Eskdale
Quaintance, R. W. — Lundale
Roberts, R. W. — Man
*Round, F. L. — Holden
Rowan, W. S. — Logan
Rubisoff, Reuben — Logan
Scott, Robert K. — Lorado
Smith, B. D. — Omar
Smith, T. C. — Slagle
‡Starcher, E. H. — Earling
Steele, L. E. — Logan
Stumbo, J. A. — Logan
Sutphin, Mark — Logan
Taylor, W. B. — Ethel
Thornbury, J. W. — Man
Traul, J. B. — Princeton
Traul, R. E. — Logan
Van Hoose, Harold — Mallory
Vaughn, R. R. — MacBeth

MARION

‡Baron, L. E. — Mannington
Barr, J. M. — Worthington
‡Blanton, J. L. — Fairmont
Bonnar, James M. — Fairmont
Bressler, David — Monongah
*Brownfield, G. H. — Fairmont
Carter, C. J. — Fairmont
Causey, H. D. — Fairmont
Clinton, J. B. — Fairmont
Collins, J. C. — Fairmont
Criss, H. L. — Fairmont
Davis, J. W. — Baltimore, (Md.)
‡Evans, Geo. T. — Fairmont
‡Fleming, H. C. — Fairmont
‡Frye, R. R. — Mannington
Hamilton, D. D. — Mannington
Helmick, John P. — Fairmont
Hickson, Edward W. — Fairmont
*Holland, C. L. — Fairmont
Holland, E. A. — Fairmont
Jenkins, J. J. — Farmington
Jenkins, J. J., Jr. — Farmington
*Johnson, H. R. — Fairmont
‡Johnson, Philip — Fairmont
‡Jones, R. Harold — Fairmont
Keister, H. S. — Fairmont
Kinney, C. L. — Ida May
‡Lambert, L. R. — Charleston
Lawson, C. S. — Fairmont
*Leahy, W. J. — Mannington
‡Mallamo, J. T. — Fairmont
Maxwell, J. S. — Fairmont
Miller, G. R. — Fairview
Moore, P. G. — Mannington
Morgan, G. V. — Fairmont
Norris, L. D. — Fairmont
Nunnally, Wm. Ord — Fairmont
Orr, W. W. — Rachel
Parks, C. L. — Fairmont
‡Parks, Seigel W. — Fairmont
Ramage, C. M. — Fairmont
Rogers, F. B. — Fairmont
Romino, J. D. — Fairmont
Sowers, F. F. — Fairmont
Spencer, L. O. — Fairmont
Swisher, K. Y. — Fairview
Trach, J. M. — Fairmont
Trach, J. P. — Fairmont
Traugh, G. H. — Fairmont
Tuckwiller, J. R. — Fairmont
Vacheresse, Edw., Jr. — Fairmont
‡Van Horn, K. L. — Fairmont
Watson, Clyde — Patterson, (Cal.)
Welton, W. A. — Fairmont
Wilson, I. O. — Van
Wise, E. D. — Fairmont
Yost, Herschel R. — Fairmont
Yost, Joe — Fairmont
Yost, Paul — Fairmont

MARSHALL

‡Ashworth, Harold — Moundsville
Ashworth, R. A. — Moundsville
Benson, Don S. — Moundsville
‡Boggs, W. C. — Wheeling
Bone, B. F. — Moundsville
‡Bradford, Wm. P. — Moundsville
Covert, O. F. — Moundsville
Ealy, D. B. — Moundsville
*Fortney, M. J. — Hundred
Grimm, R. B. — Cameron
Hartwig, W. B. — Wheeling
Hill, W. G. C. — Moundsville
Luikart, J. H. — Moundsville
‡McIlvain, W. E. — Moundsville
Peck, J. C. — Moundsville
Striebich, J. A. — Moundsville
Yoho, S. F. — Moundsville

MASON

Barker, D. C. — Pt. Pleasant
Bryant, R. F. — New Haven
Koenigsberg, M. — Pt. Pleasant
Long, Frank — Pt. Pleasant
McElfresh, Edward V. — Pt. Pleasant
Petty, C. W. — Hartford

MERCER

‡Bertling, M. H. — McComas
Bird, Ben W., Jr. — Princeton
Blaydes, J. E. — Bluefield
Calvert, J. W. — Lamar
Clements, B. S. — Matoaka
Connell, H. R. — Bluefield
‡Davis, H. C. — Bluefield, (Va.)
Davidson, S. G. — Bluefield
Fox, J. Francke — Bluefield
Fox, P. R. — McComas
‡Fugate, R. C. — Bluefield
Gammage, F. V. — Bluefield
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THE TIME ELEMENT

In the practice of medicine the importance and significance of the time element is frequently unrecognized. Many lives have been sacrificed on the altar of delay. This might be interpreted as a sad commentary on medical education and clinical acumen, if the entire truth were told.

Possibly the whole matter goes back to too much emphasis on scientific education. What a curious statement! Scientific education should make our professional service of infinite value. However, it often results in just the opposite. Our clinical sense is subjugated to scientific methods. If these do not confirm the diagnosis, or if they point to something else, we all too often supinely give up our clinical opinion, and lean completely on the scientific data for the diagnosis. — *Pennsylvania Medical Journal.*

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County Society News

BARBOUR-RANDOLPH-TUCKER

The organization of a Woman's Auxiliary to the Barbour-Randolph-Tucker Medical Society was approved at the regular monthly meeting held at Thomas, December 16, 1943.

The following officers were elected for 1944: President, M. H. Maxwell; first vice president, H. F. Parker; second vice president, E. O. Wright; secretary-treasurer, Guy H. Michael; board of censors, W. E. Whiteside, J. Ralph Woodford, and W. G. Harper.

GUY H. MICHAEL, M. D.,
Secretary.

BOONE COUNTY

At the regular monthly meeting of the Boone County Medical Society, held at Madison, November 24, 1943, Dr. V. L. Lance, of Charleston, delivered an interesting address on the subject of "Bronchoscopy: The Management of Foreign Bodies in the Food and Air Passages." The talk was supplemented by interesting x-ray films on the subject.

Dr. David H. Hill, of Madison, was elected to membership in the society.

A. C. LEWIS, M. D.,
Secretary.

CABELL COUNTY

Dr. Samuel Iglauer, Professor of Otolaryngology at the University of Cincinnati College of Medicine, was the guest speaker at the regular monthly meeting of the Cabell County Medical Society, held at the Hotel Prichard, Thursday, December 9, 1943. His subject was "Bronchoscopy."

COLE D. GENGE, M. D.,
Secretary.

HARRISON COUNTY

At the annual meeting of the Harrison County Medical Society, the following officers were elected for 1944:

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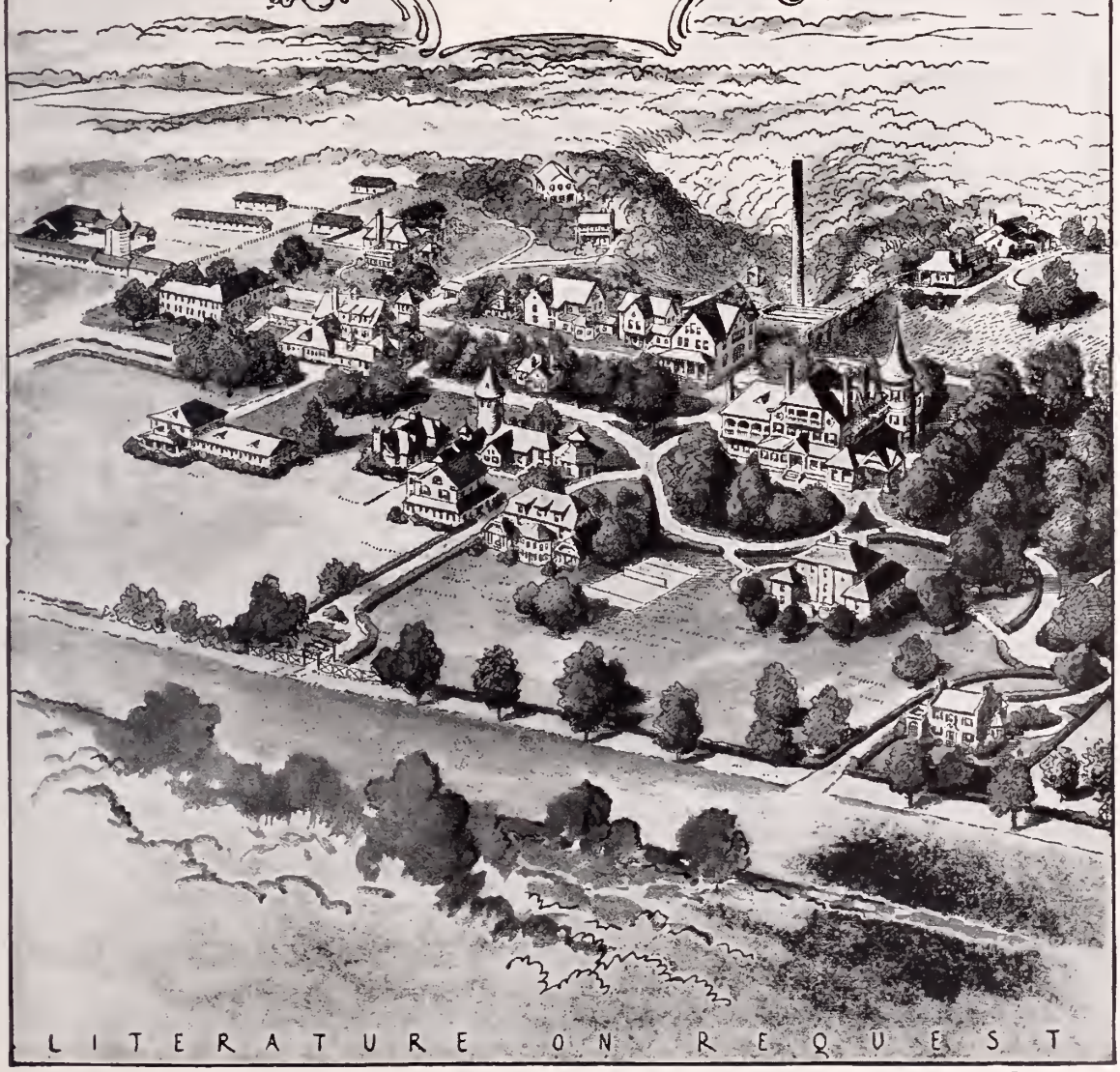

LITERATURE ON REQUEST

President, H. V. Thomas; vice president, W. T. Gocke; treasurer, C. O. Post; secretary, J. C. Kerr; delegates, H. V. Thomas, C. O. Post and J. E. Wilson; and, alternates, W. T. Gocke, D. H. Lough and B. S. Brake.

J. C. KERR, M. D.,
Secretary.

MARION COUNTY

A joint dinner meeting of the Marion County Medical Society and Woman's Auxiliary was held at Fairmont, Tuesday, November 30, 1943. After dinner, the members and several guests attended an open meeting sponsored by the Auxiliary. Dr. Hu Myers, of Philippi, delivered the principal address. His subject was, "In Defense of American Medicine." Following the address, the American Hospital Association's sound movie, "The Common Defense," was shown.

A large and appreciative audience attended the open meeting, which was conducted by the Auxiliary as part of a statewide educational campaign.

JOHN P. HELMICK, M. D.,
Secretary.

MERCER COUNTY

Two members of the staff at Ashford General Hospital, White Sulphur Springs, were the guest speakers at the regular monthly meeting of the Mercer County Medical Society, held in the Appalachian Assembly Room, at Bluefield, Wednesday evening, November 24, 1943.

Major Ralph A. Kunstadter delivered an interesting address on the subject of malaria, and Lt. Col. Leon K. Gurjian related his experiences as a medical officer in the South Pacific.

Following the meeting, the members and guests were entertained at a buffet dinner at the residence of Dr. Harry G. Steele.

FRANK J. HOLROYD, M. D.,
Secretary.

KANAWHA MEDICAL SOCIETY

Dr. Russell Haden, of the Medical Department of the Cleveland Clinic, delivered an interesting address before Kanawha Medical Society at the regular monthly meeting held at the Daniel Boone Hotel, Charleston, December 16, 1943. His subject was, "The Anemias and Their Treatment."

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A sound movie, "Plasma, Its Preparation and Use," was shown preceding Dr. Haden's address.

At the business meeting which followed the scientific session, action in the matter of accepting the medical service plan outlined at a preceding meeting was postponed until legal problems which have arisen can be definitely settled.

The following doctors were appointed as members of the program committee to arrange for the annual dinner and entertainment in January: Everett Squire, chairman, and V. L. Lance, and E. M. Peck.

GEORGE P. HEFFNER, M. D.,
Secretary.

LOGAN COUNTY

At the annual banquet of the Logan County Medical Society, held at the Rainbow Grill, Logan, Wednesday, December 8, 1943, the following officers were elected for 1944:

President, R. E. Traul; vice president, H. H. Farley; secretary-treasurer, T. H. Millman; censor (three-year term), J. L. Patterson; member postgraduate education committee (three-year term), H. H. Van Hoose.

T. H. MILLMAN, M. D.,
Secretary.

MASON COUNTY

Major Blinn A. Buell, county health officer for Mason County, was the principal speaker at the regular monthly meeting of the Mason County Medical Society, held at Point Pleasant on the evening of December 13, 1943. His subject was "Early Diagnosis and Early Reporting of Contagious Diseases to Health Officers."

The following officers were elected for 1944: President, C. W. Petty, Hartford; vice president, E. V. McElfresh, Point Pleasant; secretary-treasurer, Max Koenigsberg; delegate, Frank Long, Point Pleasant; alternate, Max Koenigsberg.

MAX KOENIGSBERG, M. D.,
Secretary.

PARKERSBURG ACADEMY

At the regular monthly meeting of the Academy of Medicine of Parkersburg, held in that city December 1, 1943, the following officers were elected for 1944: President, Fred J. Potter; vice president, Dana T. Moore; secretary-treasurer, W. F. Rogers.

A committee was appointed to make a study of a proposed medical-surgical plan to be sponsored by the Academy. This committee is composed of

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Drs. J. L. Wade, chairman; Dana T. Moore, M. A. Gilmore, S. M. Prunty, T. L. Harris, A. R. Sidell, Curtis P. Artz, Fred J. Potter and W. F. Rogers.

Dr. L. R. Leeson was accepted as a transfer from the Monongalia County Medical Society.

W. F. ROGERS, M. D.,
Secretary.

PRESTON COUNTY

At the regular monthly meeting of the Preston County Medical Society, held at Kingwood, December 2, 1943, the following officers were elected for 1944:

President, David E. Sauer; vice president, W. Parke Johnson, Jr.; secretary-treasurer, C. Y. Moser; delegates, David Salkin and H. D. Ireland; alternates, C. E. Smith and H. C. Miller.

C. Y. MOSER, M. D.,
Secretary.

Woman's Auxiliary

KANAWHA MEDICAL

A luncheon meeting of the Woman's Auxiliary to Kanawha Medical Society was held at the Charleston Woman's Club, November 9, with forty-two members in attendance. Mrs. A. A. Shawkey gave a very interesting review of James Hilton's book, "The Story of Doctor Wassell."

At the business session which followed, Mrs. C. E. Staats, corresponding secretary, submitted a report concerning the letters sent by the auxiliary members to the West Virginia congressmen protesting the passage of the Wagner-Murray bill. Mrs. J. E. Rucker, chairman of a special committee, reported progress in the matter of obtaining speakers for the educational campaign sponsored by the Auxiliary. Mrs. Robert K. Buford was appointed county war record chairman.

* * * *

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The annual Christmas party of the Kanawha Auxiliary was held at the home of Mrs. A. A. Wilson, December 14, at 8 o'clock P. M. This was strictly a social gathering and was attended by twenty-five members of the Auxiliary.

MRS. C. E. STAATS, *Secretary*.

B. FRANKLIN, MEDICAL SCIENTIST

By profession, Benjamin Franklin was a printer and publisher. Much is known of him as Franklin, the statesman, the inventor, the engineer, the agriculturalist, the oceanographer, the meteorologist, the botanist, the physicist and a host of other talents. But one of the least known facets of Franklin's multi-sided nature is that of the medical scientist. Yet his contributions to the field of medicine were important and one of his chief interests was the study and cure of disease.

Although he had no formal medical education or M. D. title, his research on the common cold, lead poisoning and other ailments, was outstanding. Some of his contributions to medical literature, such as his letters to Dr. Cadwallader Evans and Benjamin Vaughan, upon the causes of colica pictonum, and his numerous papers on catarrhs and contagious colds, have become classical.

The world is indebted to Franklin for the invention of bifocal lenses.

It was in 1784, while Franklin was ambassador to France, that he developed this important optometric discovery. The 78-year-old sage always wore glasses and he could not, without them, "distinguish a letter even of large print." But the story is best told in his own words: "Before that year I had used two pair of spectacles which I shifted occasionally, as in traveling I sometimes read and often wanted to regard the scenery. Finding this change troublesome and not always sufficiently ready, I had the glasses cut and half of each kind associated in the same circle."

Franklin's theories on the causes and cures for the common cold are essentially the sum total of what anyone today knows about that commonplace and most widespread of diseases.

Even though he could never have heard of germs or virus, Franklin deduced that colds were carried by "particular effluvia in the air." He also believed that colds were contagious.

His theory maintained that colds were spread by crowds gathered in unventilated quarters and breathing foul, stagnant air.

—*The National Franklin Committee.*

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THE DOCTOR'S WIFE

Dr. M. H. Kettle used to say that the biggest handicap of a woman doctor was that she could not have a wife. For no housekeeper or keeper, secretary or dictaphone, companion or detective service can quite take the wife's place, and so far no husband has ever tried.

A doctor's wife can make or wreck his career, but she can do far more—bring him misery in the midst of success or happiness in spite of failure. What qualities should she have if she is to give him —and therefore herself—both success and happiness? First among them McClinton of Ontario puts good health, not only for the reasons which apply to anyone's wife but because her lesser ailments will never receive the attention they deserve; she can only mention them when her husband is hurried over breakfast or tired over dinner, and she must subsist mainly on samples from his dusty shelves. It is her job to know as much as he does although not of the same subjects.

She needs no skill with the stethoscope, but must master the telephone. In two minutes she must learn the patient's name and social status, his address and how to get there, what he has and how long he has had it, and she must bear the blame if her assessment of urgency, based on the distorted tone values of a few hasty words, turns out wrong. Moreover, her reply to the message must be neither alarmingly sympathetic nor unkindly terse.

She must know how to entertain their friends, remembering that too much entertainment in the doctor's home becomes obvious and odious. She is fortunate if he worries, for if he does not, he burns with no creative fire. The good doctor will often sweat when the phone rings at night, for fear of something he has left undone, while the bad one snuggles dry beneath the blankets knowing that most people get well anyhow. Last of all—she must love the doctor. To act as such a combination of doormat and poultice she will have to.—*Lancet.*

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TUBERCULOSIS ABSTRACTS

(Continued from page 17)

with direct chest trauma or with mechanical disturbance of the lung is possible in some cases, though hemorrhage may and often does appear when the patient is at rest, perhaps during sleep. In only 28 cases in this study was there either a specific history of a precipitating factor or of its absence. In 10 patients hemorrhage was related to one or more menstrual periods.

Among the graver consequences of pulmonary hemorrhage must be listed strangling and asphyxia from massive bleeding, fatal blood loss in the cachectic patient, and the commoner and ever-present danger that blood from a cavity which is generating a positive sputum will spread the infection to other parts of the lungs, giving rise to an acute tuberculous bronchopneumonia or a massive caseous pneumonia. Obviously, repeated episodes of blood-spitting multiply the chances for such complications to occur.

Summary and Conclusions

1. In a study of 1,000 sanatorium tuberculosis patients it was found that hemorrhages occurred in 24.3 per cent of them.

2. The average size of hemorrhage was five ounces. Forty per cent of hemorrhages were eventually repeated.

3. In 60 patients, the first remarkable symptom was hemoptysis.

4. Seventy per cent of cases with a history of hemorrhage before diagnosis were properly diagnosed by the local physician, when he was consulted. However, 13 per cent were misdiagnosed.

5. Most tuberculous patients who hemorrhage have cavitation visible on x-ray examination; 83.4 per cent of this series had a positive sputum.

6. Trauma to the chest, strenuous exercise, mechanical disturbance of the lungs and, in females, the menstrual period are definite precipitating factors.

7. Small hemorrhages often occur from early lesions at the height of the catarrhal and toxemic symptoms which probably signify softening. These are not usually serious and may, in the long run, be beneficial if they call attention to an undiagnosed tuberculosis. However, larger hemorrhages which occur in chronic ulcerative tuberculosis, while rarely immediately fatal, are accompanied by many un-

pleasant and dangerous possibilities. Of the 12 deaths which occurred in the sanatorium after hemoptysis, it is felt that 5 were directly or indirectly the result of the hemorrhage.

Hemorrhage in Pulmonary Tuberculosis, George R. Minor, M.D., American Review of Tuberculosis, August, 1943.

VISUAL AREA HIGHLY DEVELOPED

Because man depends so much upon his eyes for knowledge and understanding, the visual area of the brain, situated in the cerebrum at the rear of the brain, is much more highly developed than in other animals, according to the Better Vision Institute. The visual area in the human brain is larger than the hearing area, which is located in the temporal lobe. The olfactory center of the brain occupies a small part of the cortex and the taste area, presumed to exist, has never been located.

"Spots before the eyes" usually are shadows of white blood particles moving in the interior of the eyes to feed the tissues. Ordinarily the movement of these blood particles is not noticed, but when the eyes are tired or strained, the visual nerves are so jumpy that they see the shadows which healthy eyes do not notice.

Pictures are "printed" on the retina of the eye very much like those formed on chemical plates of cameras. In the case of a photographic negative, a permanent record is desired and the negative is placed in a "fixing" bath. Because continuous vision is desired in a succession of pictures, the retina of the human eye erases the chemical changes caused by light, quickly preparing a new plate for the next picture. The eye can "take" about 10 pictures a second.

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MEDICAL EDUCATION IN WEST VIRGINIA

By EDWARD J. VAN LIERE, Ph. D., M. D., and GIDEON S. DODDS, Ph. D.
Morgantown, West Virginia

During the past few years the members of The West Virginia State Medical Association have taken a keen and healthy interest in medical education in our state. Those members who attended the annual meeting held in Charleston last May, may have found time to study briefly the exhibit which had to do with premedical and medical education. As there is such a need for physicians at the present time, and medical education is such a live topic, it was thought worthwhile to publish some of the charts which were exhibited in Charleston, and also to give a brief survey of premedical and medical education in the state. It appeared to the authors that in order to provide a proper background it would be in order to present briefly the history of the medical school in the state of West Virginia.

HISTORICAL BACKGROUND

It was suggested by Dr. Martin, the first president of the university, in his inaugural address in 1867, that besides the usual courses of arts and law the university should have a school of medicine. Four years later, in 1871, the university started to give instruction preparatory to the study of medicine and offered courses in anatomy, physiology and hygiene. Dr. John N. Simpson, now dean emeritus of the West Virginia University School of Medicine, in 1902 became head of the departments of anatomy and physiology and organized the first two years of a standard four-year medical course.

An arrangement was made with the trustees of the College of Physicians and Surgeons (now the Medical School of the University of Maryland) whereby the students took their first two years of medicine at West Virginia University and then com-

THE AUTHORS

Dr. Van Liere, graduated Harvard Medical School; Ph. D., University of Chicago, Dean of Medical School and Professor of Physiology, West Virginia University; Fellow American College of Physicians; American Physiological Society.

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pleted their medical education at the College of Physicians and Surgeons. This relationship was severed after a few years by the board of regents of the university and the present School of Medicine was established in 1912.

The requirements for admission when the School of Medicine was first organized were either a four year high school course or a "No. 1" teacher's certificate. However, even with this modest requirement, few students could qualify for admission and the classes were small. At this time there were approximately 168 medical schools in the United States. On the whole, low standards of education prevailed and in some instances medical schools were in actuality only night schools. After a few months' attendance at one of these latter schools a man could obtain a medical diploma and start the practice of medicine. It was reported that in one medical school the only equipment available was a human skeleton and it was not complete. In 1909 the first classification of medical schools by the Council on Medical Education and Hospitals of the American Medical Association and the Carnegie Foundation was published. Many of the weaker schools closed as a result of this classification and there are now about 80 medical schools in the United States and Canada.

ENROLLMENTS RESTRICTED

Shortly after World War I more and more students became interested in the study of medicine as a career and soon the approved medical schools found it necessary to restrict their enrollment because their laboratory and clinical facilities could accommodate only a certain number. Since the West Virginia University School of Medicine was a tax supported school, those who were responsible for the administration of the school at that time, felt that all West Virginia students who applied for admission and who met the hour and subject requirements should be accepted. The classes became increasingly large, and in 1934, 83 students, including a considerable number of nonresidents, were accepted for the freshman class. A total enrollment of 145 was the largest enrollment ever attained. (See Chart 1). During these years the classes

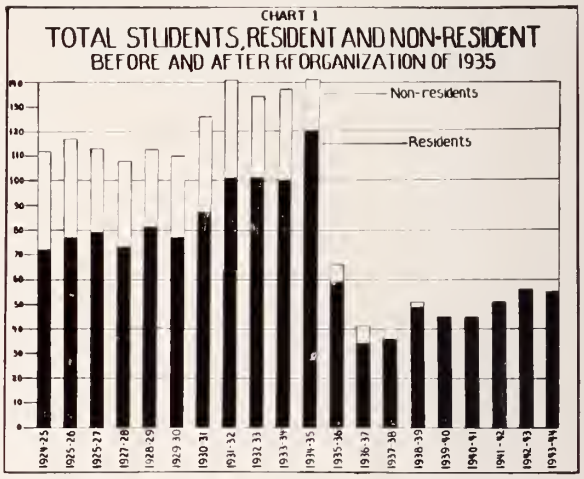

Chart 1. Shows total students by years for twenty years, before and af er the reorganization of 1935 (West Virginia residents and nonresidents). In 1935 the school was removed from the approved list. In 1937 approval was restored after a complete reorganization. At that time the size of the student body was greatly reduced, and only West Virginia residents can now be admitted.

were so large and many of the students so poorly prepared that from 25 to 45 per cent failed in their work.

MEDICAL SCHOOLS AND ACCREDITING AGENCIES

In the autumn of 1934 the two accrediting agencies of the North American continent, namely, the Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges, began a reinspection and reevaluation of all medical schools, the first general inspection since 1919-20. The school failed to meet the standards of either of the accrediting agencies and it was therefore necessary to reorganize it completely. This reorganization was begun in the summer of 1935 by the authors of this paper, who were appointed by the university administrative officers as a special committee for this responsibility.

It is of distinct interest to those who are earnestly concerned about medical education in West Virginia that the criticisms of the school were as follows:

1. The policy of the school seemed largely influenced by partisan politics.

2. Too many students were admitted; many of them were poorly qualified.

3. The faculty was inadequate in size and excellence.

4. The income of the school was inadequate.

5. The physical plant was totally inadequate for the student body.

6. The medical library was undeveloped.

The reorganization for the correction of these deficiencies followed the educational policies of modern medical schools of good standing, as far as they were applicable to a school giving only the first two years. The classes were reduced to a size which could be efficiently handled in the available space, and the students were carefully chosen. (See Chart 2). The faculty was thoroughly reorganized and several capable and well trained men were added. The clinical courses, namely, physical diagnosis, medicine and surgery were entirely revised and considerably expanded. This was not difficult to accomplish because there were two hospitals in Morgantown with a combined capacity of about 250 beds. An agreement also was made with the Hopemont Sanitarium, an institution with a capacity of 450 beds, that during their last semester all of our students should receive two weeks of resident training in physical diagnosis. At the same time more adequate funds were secured for salaries, equipment and maintenance, and since then very careful attention has been given to the expenditure of these funds. Plans were matured for the better organization and support of the medical library.

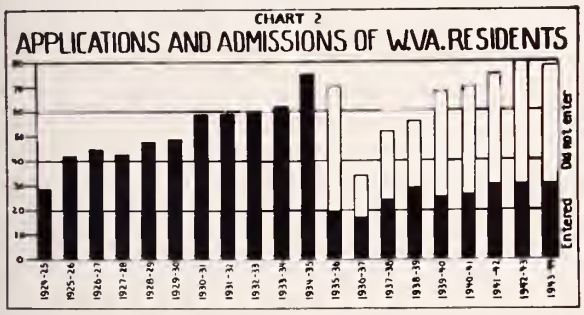

Chart 2. Shows applications for admission by West Virginia residents (many nonresidents apply but are not included in the chart). Before 1935 all resident applicants (and some nonresidents) were admitted. The uncertainty caused by the withdrawal of approval caused a temporary decrease in the number of resident applicants. The maximum number now admitted to the first year class is 30.

During the past eight years the administration of the school has attempted to maintain these standards, and the writers believe the results have well justified the vigorous and continued effort necessary. A very gratifying feature of the work of these recent years has been the sympathetic support of the university administration and the board of governors as well as the growing interest evinced by the physicians of the state.

THE SELECTION OF STUDENTS

Possibly the entrance requirements now in force should be stated more fully, inasmuch as they are quite in keeping with those of other medical schools on the approved list. Beginning with the entering class of 1935, selection of students was and still is, made on the following basis:

1. Nonresidents of the state considered only after all eligible residents were admitted (this has practically eliminated nonresidents).

2. Three years of college work required.

3. The medical aptitude test required and used in the selections. (A special section on this test follows).

4. Personal qualifications considered, based upon recommendations and interviews.

5. A scholarship standard enforced, no students being admitted who, on the basis of past experience had grades so low as to make success practically impossible.

6. Students from colleges not on the approved list of the A. M. A. not to be admitted unless showing distinctly superior scholarship and ability.

The selections based upon the above principles have been administered by a Committee on Entrance and Scholarship, the membership of which has included the professors of anatomy, biochemistry, histology, pathology, and pharmacology. The approval of the dean also is necessary. The school has striven to carry out impartially these provisions for the selection of students, but this has been by no means an easy matter. The selection of medical students is often a difficult task because

there are always more applicants than can be accepted in accredited schools. The problem of selection of medical students during war time is especially trying. At the present time medical students are deferred; their tuition is paid and their books are supplied and besides this they receive a commutation of $2.75 a day and $50 a month from the Army. Applicants often come armed with letters from their friends and from influential citizens in the state. It is to the everlasting credit of these influential citizens that never have they made a serious attempt to influence the decision of the Committee on Entrance and Scholarship.

THE MEDICAL APTITUDE TEST

Inasmuch as there are about twice as many applicants as the schools can accommodate, medical educators have been seeking improved means for evaluating the many applicants. In the latter twenties a concerted attack upon this problem was made by the Association of American Medical Colleges, which was organized in 1891, and now includes all of the 83 approved medical schools in the United States and Canada.

One result of such study was the formulation of a special test, known as the Medical Aptitude Test, to be given annually to prospective medical students, so that the admission officers might have this additional and uniform information about the capabilities of the applicants. The test was developed and is still administered by a committee composed of members of the Association of American Medical Colleges and headed by Dr. F. A. Moss, M. D., a psychiatrist, and professor of psychology at George Washington University in Washington, D. C.

A suitable test is prepared by the committee each year and it is given at the same time and under carefully standardized conditions in all of the participating colleges. The test is proctored by local men, but the papers are graded by the central committee and the results are distributed to the institutions. The grades are considered confidential and are not given to students or any unauthorized persons. One purpose of the test is to provide a standard set of grades the country over so that there may be some measure other than the premedical college grades, which vary greatly in their strictness among the different institutions. The tests are designed to measure the following abilities: (1) visual memory, (2) memory for content, (3) general information, (4) understanding of printed matter, (5) vocabulary and (6) application of principles. Beginning with 1930, the test has been given each year to approximately 10,000 students in about 600 different institutions giving premedical work.

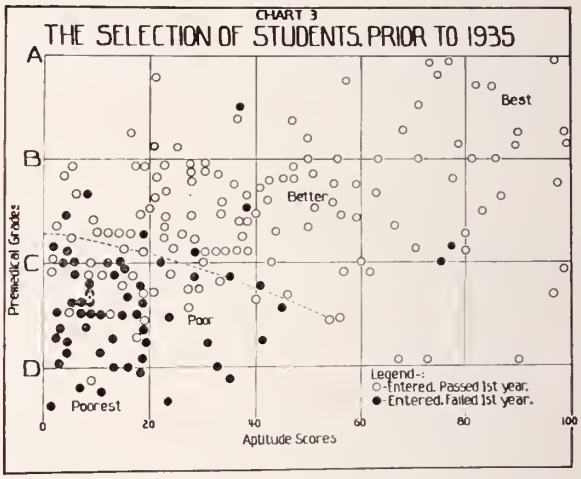

Chart 3. Scattergram showing the premedical standing of 194 students in three large, unselected classes entering in 1932-34. Average premedical grades measured from bottom to top; medical aptitude scores from left to right. Students low in both of these were almost sure to fail in the first year; students high in both had no failures. In these years there were no scholarship qualifications for admission, and the entering class sometimes had as many as 80 students. The first year failures were from 25 to 45 per cent.

Our medical school, in common with many others, has found the test score a very useful and helpful supplement to other available information. In general, applicants with the better premedical grades have the higher test scores and vice versa, but there are exceptions. These exceptional cases are the ones which are difficult to judge. Studies of our applicants made during the past ten or more years have shown that this test, on the average, gives as good a predictive measure of success in medical school as do premedical grades. Some schools do not consider the admission of applicants whose scores place them in the

lowest third of those taking the test, but our school has not been able to set such a strict standard, because those taking the test in our area have had scores too low to permit such a strict use. We have found, however, that students with the higher premedical aptitude scores are far superior to those with the lower scores, and though we have taken students even in the lowest tenth, these students are almost without exception unsatisfactory.

Chart 3 shows first year medical failures with reference to premedical grades and aptitude scores in the large classes when there was no selection on the basis of scholarship. Chart 4 shows how this information is now used in the selection of students.

THE PHYSICAL PLANT

The building which is now used by the School of Medicine was constructed in 1914 at a cost of only $18,000. Since there were but few medical students at that time, the School of Pharmacy also was housed in this building, as was the State Hygienic Laboratory. Even at the start, however, the building

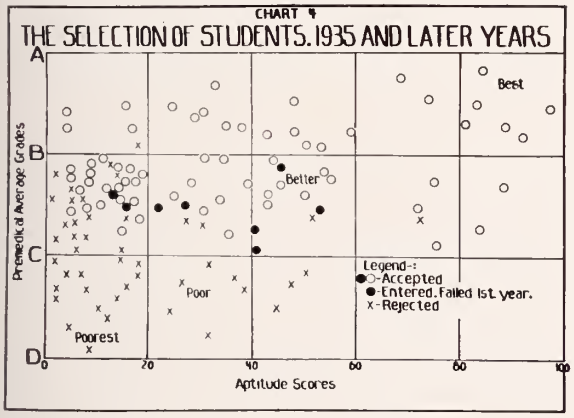

Chart 4. Scattergram showing 121 applicants for two years, 1941 and 1942, showing how students are accepted on the basis of scholarship. The students rejected are largely those low in both premedical grades and medical aptitude scores (records like those of students who formerly failed. See Chart 3). A few are rejected for other reasons. The first year failures are much reduced by this selection and are mostly in the lower fringe of the admissions. A few other students, while not actually failing, have unsatisfactory records.

was inadequate, since proper provision had not been made for private laboratories and offices and virtually no space was provided for storage, and none at all for animal quarters.

In 1919 the School of Pharmacy moved to its present quarters, the basement of Woodburn Hall, and a year or so later the State Hygienic Laboratory was moved to Charleston. Thus, more room was made available for the teaching of medical students. In the late twenties, as the medical classes became larger, the department of biochemistry was moved to the fourth floor of the commodious Chemistry Building. Two years ago when the new Health Service Building became ready for occupancy the departments of pathology and clinical microscopy were installed on the second floor; these departments are splendidly housed and equipped—second to none in the country. At present, therefore, there are only four major departments in the Medical Building, namely, anatomy (both gross and microscopic), bacteriology, pharmacology, and physiology. It should be stressed, however, that all of these departments are inadequately housed.

NUMBER OF STUDENTS SCHOOL CAN ACCOMMODATE

Even though three major departments have moved out of the Medical Building, at present only 30 medical students in each class can be accommodated. In point of fact the laboratory of physiology has space for less than that number. We are cognizant of the recommendation which the Council of the State Medical Association has made, namely, that the first year enrollment of the medical school should be increased to 40 or more students. However, at the present time lack of space precludes this and the enrollment cannot be increased until a larger building is available. It is to be regretted that the Medical Building cannot accommodate larger classes, since each year there are always a number of desirable West Virginia students who cannot be accepted.

THE VALUE OF THE MEDICAL SCHOOL TO WEST VIRGINIA

The writers of this paper, who have been on the faculty of the School of Medicine for about twenty-five years, have had opportunity for extended personal observation of the school and its outside relations. They have also learned much of its earlier history

through several years of association with Dr. Simpson, who guided it from the time of its organization in 1902 until his retirement in 1935. It is our firm opinion that the School of Medicine has been a distinct asset to the state, and has amply justified the outlay necessary for its maintenance. It has furnished a place where a goodly number of the young people of the state have made the beginning of their medical training at a very reasonable cost. During the years since its organization in 1902, forty classes, including over 1,100 students, have completed the two years offered. (See Chart 5). Nearly all of these

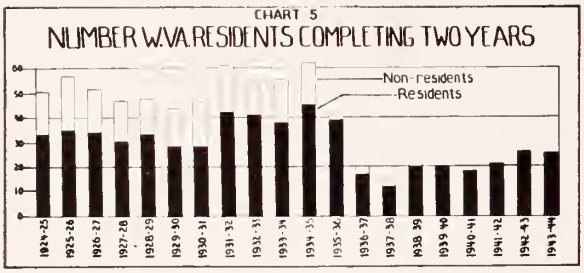

Chart 5. Shows number of students completing the two years offered (residents and nonresidents). In the years immediately following the reorganization in 1935, the number of graduates decreased greatly, but it is again growing, and the number of resident graduates is approaching the number for some of the years when admission of residents was unrestricted.

students have subsequently completed the requirements for the M. D. degree in other accredited medical schools, and have entered the practice of medicine, many of them in West Virginia. It would seem also that the maintenance of this school has a distinct value in the mere circumstance of keeping alive the idea that medical education is one of the functions of this state. But the medical school has made another, though possibly a less evident contribution, to the general educational progress of the state. It is well known that the presence of a medical school on a university campus has a distinctly stimulating effect upon the university as a whole. This has been very true at West Virginia University. The presence of the medical school has greatly stimulated the development of premedical education in the university, and thus has been an important factor in the growth of the various science departments, such as biology, chemistry, physics, and psychology, and also in the bringing of students to the departments of English, foreign languages, history and social studies. Moreover, the presence in the university of the serious group of mature medical students has been without doubt a useful element in the intellectual atmosphere of the student body. The effect of the medical school upon the content and policy of the university library has been marked and beneficial. Likewise, one cannot ignore the general value of a compact and scientifically trained faculty to the general scholastic atmosphere of the university, both in the fields of teaching and research. It is a matter of gratification that even in the years when the school was failing in some respects to measure up to acceptable standards, its staff was doing much teaching of a high order, and some departments were carrying on original investigations leading to the discovery and publication of new facts. During recent years the departments of anatomy (both gross and microscopic) bacteriology, biochemistry, pathology, pharmacology and physiology have been especially active in research, and have published many papers in standard scientific journals with national and even international circulation. These publications, some of which have been very fundamental and timely, have drawn much favorable attention not only to the university but to the state.

PREMEDICAL EDUCATION IN WEST VIRGINIA

An important phase of the training of the modern physician is the laying of a sound educational foundation before entering medical school. Medical schools have come more and more to demand this, and prospective students to recognize its value. As a result the amount of preliminary collegiate training presented by applicants has been steadily increasing during recent years. This trend is undoubtedly a response to the need for capable students who can carry successfully the difficult medical curriculum, which steadily has grown more extensive with the rapid expansion of medical knowledge.

To provide this preliminary training there

has developed throughout our country an entirely new phase of collegiate work which has become generally known as "premedical education." Colleges of arts and sciences have turned to it with avidity. Departments of biology and chemistry are vying with each other for preeminence in this program, while other departments, both scientific and literary, are finding the serious premedical students a distinct asset at a time when nonprofessional education has become relatively less popular than it once was. Premedical collegiate education does not consist of special premedical courses, but rather of a suitable combination of ordinary courses in sciences and other subjects, the whole program designed to prepare the student for both the study of medicine and intelligent citizenship.

So great has been the movement for premedical education, that there has grown up a premedical fraternity with a goodly number of chapters. So important is premedical training considered that the American Medical Association publishes annually an approved list of colleges of arts and sciences, which now includes over 650 institutions. Approved medical schools are privileged to admit students from nonapproved colleges only when they show evidence of distinctly superior ability.

TRAINING AND GUIDANCE OF STUDENTS

In premedical education West Virginia has not been backward. Most of its colleges try to make a feature of this kind of preparation. The university with its larger facilities, and under the immediate influence of the medical school, has been especially active in this program and has built up a very effective organization for the training and guidance of students looking toward medicine, dentistry, or nursing. In West Virginia the following institutions are on the approved list: Bethany College, 27 premedical students; Concord State College, 6; Marshall College, 90; Potomac State College, 24; West Liberty State College, no report; West Virginia Wesleyan College, 20; West Virginia University, 335. In addition there are perhaps about 40 premedical students in the several nonaccredited institutions, making a total of nearly 550 premedical students in the state. The above figures are reasonably accurate and show about how many students were normally following the premedical curriculum before our entry into the war. The School of Medicine, through its Committee on Entrance and Scholarship, keeps in fairly close touch with most of these institutions, and is glad to report a most cordial and beneficial relationship.

Of course, by no means all West Virginia premedical students take their work in the colleges of their own state. There are always a considerable number, who, for various reasons, attend colleges elsewhere, chiefly convenient colleges in the adjacent states, though some attend the large universities more distantly located. There is no way of knowing how many of such students there are, but they are much more likely to apply for admission to other medical schools than to the one in their own state.

WEST VIRGINIA RESIDENTS APPLYING TO MEDICAL SCHOOLS

Statistics published by the Association of American Medical Colleges show that year by year the number of applicants from each state remains rather constant so that the states maintain about the same order year after year. In the eight years immediately preceding our entry into the war, 1934-1941, the average number of residents of West Virginia applying for admission to all medical schools was 156, with extremes of 196 and 134. This means that there were 82 applicants for each million of population of the state, a value which falls in the substantial middle range of all the states. (See Chart 6). Thus, there is shown a consistent, healthy desire on the part of our young men and women to enter the study of medicine.

There are no available figures telling how many of these applicants were admitted to medical schools, but on the basis of the national average and our own experience, about half of them were. These applicants constitute a group from which a four-year

medical school in the state might expect to draw easily a sufficient number of well qualified students each year, even allowing for a considerable number who always prefer to go to various schools outside the state. In the past eight years the average number of state residents applying for admission to our own medical school has been about 75. But there

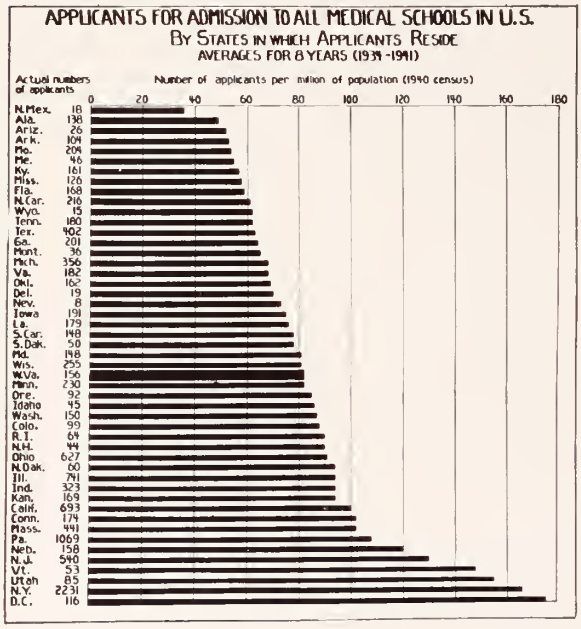

Chart 6. Shows total number of applications for admission to all medical schools by residents of each state (column of numbers), and the number of applications per million of population (black bars). West Virginia occupies an intermediate position among the states in the proportionate number of applicants, though the actual number is by no means as large as in some of the more populous states. The numbers of applicants are from annual reports by the Association of American Medical Colleges; the proportionate numbers and the graphic exoression were prepared by the authors.

is every reason to believe that this number would be increased if we had a four-year school which would obviate the uncertainty of transfer at the end of the second year. In the past, this factor has kept a good many excellent students from applying here, or from entering if they could secure admission elsewhere. The new agreement with the Medical College of Virginia should do much to change this picture.

WEST VIRGINIA RESIDENTS IN MEDICAL SCHOOLS

There are no figures available from which to compute the total number of West Virginia residents actually attending medical schools, but the reports on medical education published annually by the American Medical Association show that in the past five years, the average attendance by persons born in the state has been 275, a figure which doubtless gives a reasonable approximation of the number now residing in the state. About 55 of this number have been in attendance each year in the two classes of our own medical school. The others were attending 44 other schools, chief of which are the following: Medical College of Virginia, average of 52 students; University of Maryland, 26; University of Virginia, 12; Duke University, 11; University of Louisville, 9; University of Pennsylvania, 9; Jefferson Medical College, 8; Western Reserve, 6; Temple University, 6; Johns Hopkins, 3. Some of the students listed from the above schools were at one time in the Medical School of West Virginia University where they completed the first two years.

TRANSFER OF STUDENTS FOR THIRD AND FOURTH YEAR

During the past twelve years, students who have completed two years at West Virginia University School of Medicine have transferred to 37 different medical schools for the completion of their work. The following table gives the aggregate number for each school:

N. Y. Univ. (Bellevue)	10
Boston Univ.	2
Columbia Univ.	1
Duke Univ.	4
Emory Univ.	5
N. Y. Med. Coll. (Flower Hosp.)	1
Georgetown Univ.	2
Geo. Washington Univ.	2
Hahnemann Med. Coll.	8
Harvard Univ.	3
Jefferson Med. Coll.	5
Johns Hopkins	2
Long Id. Coll. of Med.	1
Louisiana State Univ.	8
Loyola Univ.	2
Med. Coll. of the State of S. C.	11
Med. Coll. of Va.	81
Northwestern Univ.	28
Ohio State Univ.	5
Rush Med. Coll.	74

Temple Univ.	40
Tulane Univ.	1
Univ. of Arkansas	6
Univ. of Chicago	3
Univ. of Cincinnati	7
Univ. of Georgia	2
Univ. of Louisville	25
Univ. of Maryland	22
Univ. of Michigan	1
Univ. of Pennsylvania	19
Univ. of Pittsburgh	1
Univ. of Rochester	1
Univ. of Tennessee	2
Univ. of Virginia	2
Univ. of W. Ontario	1
Vanderbilt Univ.	3
Washington Univ.	18

This tabulation gives a concrete picture which readily suggests the seriousness of the problem of transfer.

AGREEMENT WITH VIRGINIA

Although as previously mentioned the Medical School of West Virginia University had an affiliation at one time with the College of Physicians and Surgeons in Baltimore (now the Medical School of the University of Maryland), this was but short lived and indeed was not generally known.

Plans have been recently matured whereby as many as twenty students, who have completed two years at the School of Medicine of West Virginia University, may continue their medical education at the Medical College of Virginia at Richmond, Virginia. Special legislative enactment made the plan possible.

The cooperative agreement with the Medical College of Virginia was first conceived by Dr. R. J. Wilkinson. Dr. R. K. Buford, who was president of The West Virginia State Medical Association in 1940, appointed a committee, which consisted of Dr. Robert J. Wilkinson, chairman; Dr. Frank V. Langfitt, and Dr. Edward J. Van Liere, to study problems of medical education in the state. It is not necessary to outline in detail the recommendations of this committee, since these may be found in THE WEST VIRGINIA MEDICAL JOURNAL.[1] The final realization was guided by a larger committee including Dr. Ray M. Bobbitt and Dr. Frank J. Holroyd.

The legislative bill which made it possible for 20 students to be transferred automatically to the Medical College of Virginia passed both houses of the state legislature without a dissenting vote; it was then signed by Governor Neely and the bill became a law.

Since very cordial relations have existed between the medical professions of Virginia and West Virginia and also between the Medical College of Virginia and West Virginia University School of Medicine, the cooperative agreement previously described seems to be a happy solution of the present problems of medical education in West Virginia. It is certainly to be hoped that this plan will serve for a few years until the State of West Virginia is in a position to establish and maintain a four-year school of its own.

THE FUTURE OF MEDICAL EDUCATION IN WEST VIRGINIA

During these uncertain times it is difficult to prognosticate the future of medical education in West Virginia. The state has a population of approximately 2,000,000. It has shown a healthy growth in population during the past few years and with the development of industry there is every reason to believe that this growth will be accelerated. As the population of the state increases more physicians will be needed and also there will be more young men seeking to enter medical schools. It is becoming increasingly difficult for young men to be accepted into approved medical schools, for nearly all state institutions limit their enrollment to bona fide residents of the state, as does West Virginia.

It is true that there are medical schools throughout the country which are not affiliated with state universities, but in most instances there is keen competition for places in these schools and only students who have a high scholastic standing are admitted. Also, the tuition is often very high.

It would seem, as the state grows in population and wealth, that in the not far distant future it should be able to support a four-

year medical school. When that time comes, even as now, the school will need the wholehearted support of the medical profession of the state.

Finally, it has been a matter of great satisfaction not only to the administrators of the medical school but to the administrators of the university proper as well, that the members of The West Virginia State Medical Association during the past few years have given the School of Medicine their loyal support. In his presidential address, Dr. Wilkinson stated, "I am happy to tell you that there exists today, as never before, a closer relationship between the medical profession and our medical school at West Virginia University."[2] Indeed, this was well said and it is to be hoped that this close relationship will continue. The authors of this paper always have been of the opinion that organized medicine in West Virginia should play a distinct part in the development of medical education in the state.

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HERNIATION OF STOMACH THROUGH ESOPHAGEAL HIATUS IN DIAPHRAGM: STATISTICAL ANALYSIS OF FIFTY-SEVEN CASES

By WILLIAM KAY, M. D., and PORTER P. VINSON, M. D.
Richmond, Virginia

During the past twenty-five years herniation of abdominal viscera through the diaphragm has been recognized with increasing frequency. There is little reason to suspect an actual increase in the number of patients suffering from most types of diaphragmatic hernia, although crushing injuries to the thorax from automobile accidents may have added to the incidence of the traumatic variety. The increase in the recognition of diaphragmatic hernia has resulted from improvement in methods of examination and greater alertness on the part of clinicians. Numerous authors have reported fairly large groups of patients who have been operated on for various types of diaphragmatic hernia, with satisfactory results and low mortality rates. The purpose of this report is to analyze statistically the symptoms and clinical findings in 57 of 59 patients with esophageal hiatal hernia that we have observed during the past six and one-half years.

The so-called short esophagus type of diaphragmatic hernia is really not a hernia but a congenital abnormality in which a portion or all of the stomach has developed above the diaphragm. We shall refer to the condition in this group of patients as congenital shortening of the esophagus with hernia.

THE AUTHORS

Dr. Vinson, graduate University of Maryland; interned Trudeau Sanatorium, Montreal General Hospital; Mayo Clinic, 1916-1936; Professor of Broncho-esophagology, Medical College of Virginia; Fellow American College of Physicians; American Broncho-esophagological Association.

Dr. Kay, graduate Medical College of Virginia, 1943; intern at Medical College of Virginia Hospital, Richmond.

ANALYSIS OF MATERIAL

Fifty-six of our patients were white and 3 were Negroes. Forty-five had hernia of the type associated with shortening of the esophagus; of this group, 26 were women and 19 were men. The remaining 14 had hernia of the paraesophageal type, 10 being women and 4 men. The ages varied from three to eighty-three years. Three patients were less than thirty-one years of age; 3 were between thirty-one and forty; 10 were between forty-one and fifty; 18 were between fifty-one and sixty; 19 were between sixty-one and seventy;

3 were between seventy-one and eighty, and 1 patient was eighty-three years old.

SYMPTOMS

The duration of symptoms varied from a week to the entire lifetime, and it is interesting to speculate why patients with a congenital abnormality, such as occurs in shortening of the esophagus with hernia, should not have symptoms until the age of sixty years or over. In paraesophageal hernia it can be assumed that a certain size must be attained before symptoms are produced, but in the short esophagus type the portion of stomach above the diaphragm probably does not increase in size during the years. It is difficult, therefore, to explain why all patients with this type of hernia do not experience discomfort from early childhood.

In the analysis of symptoms we have considered both types of hiatal hernia together, for in the majority of patients differentiation seldom can be made on the history alone. The three outstanding symptoms are pain, dysphagia and flatulence.

Pain is usually experienced high in the epigastrium and frequently radiates substernally to the neck and down one or both arms. In many patients the character of the discomfort is identical with that produced by gallstones, coronary disease or cardiospasm. Forty-five of our patients had varying degrees of pain; in 17 cases it was mild and frequently associated with obstruction to solid food in the esophagus; in 16 cases it was of moderate severity and in 12 it was of such severity that it was, in most instances, thought to be due to occlusion of one of the coronary arteries. Several of our patients later died, apparently of disease of the coronary arteries, and the possibility of heart disease associated with hiatal hernia should always be borne in mind.

Dysphagia was noted in 43 patients. The striking features of dysphagia in patients with hiatal hernia are that the difficulty in swallowing is almost always intermittent and that solid food is usually the only type that becomes lodged in the esophagus. Regurgitation is seldom noted unless the esophagus becomes completely obstructed by a bolus of solid food, which usually is a piece of meat. Dysphagia was mild in 9 of our patients and moderately severe in 24; 10 had had periods of complete obstruction of the esophagus that persisted for as long as twenty-four hours. Several patients required esophagoscopy for removal of a piece of meat that had occluded the esophagus above the hernia. In 7 of the patients who suffered from dysphagia there was a short cicatricial stricture in the esophagus, whereas in 36 dysphagia apparently resulted from spasm. Significant loss of weight was noted in 13 patients and was dependent on the severity of the dysphagia.

FLATULENCE CHIEF COMPLAINT

Flatulence was frequently the chief complaint and was a prominent symptom in 40 of our patients. The discomfort was especially pronounced after meals and when the patient lay down. Many patients had found that this symptom was accentuated when food was taken within an hour or two of retiring. Occasionally, relief from gaseous distention was obtained by the patient's assuming an erect posture. Bleeding from the esophagus occurred in 14 of our patients; in 6 hemorrhage was severe, whereas in 8 the amount of blood that was vomited was small. In several patients hemorrhage had been precipitated by an attempt to force into the stomach a bolus of food that had obstructed the esophagus. Stagnation of food in the lower portion of the esophagus is probably the cause of ulceration, which results in bleeding and formation of cicatricial stricture in the short esophagus type of hernia. The cause of stricture in the lower portion of the esophagus in cases of paraesophageal hernia is not readily explained. Bleeding in these cases is apparently due to ulceration in the stomach at the point at which the diaphragm produces constriction.

Dyspnea, another symptom of diaphragmatic hernia, was noted in 5 patients only, and it was apparently unrelated to the amount of stomach that lay within the thorax. With some of the largest hernias shortness of

breath was not noticeable. Hiccup, although not a particularly objectionable symptom, was noted by a considerable number of our patients.

TREATMENT

The method of management of hiatal esophageal hernia depends on the type of hernia, the character and severity of symptoms, and the age and general condition of the patient.

In cases of short esophagus type of hernia, operation is seldom required, and even when it is possible to place all the stomach below the diaphragm, symptoms may persist or the hernia may recur. In almost all patients with this variety of hernia, especially when dysphagia is the major complaint, relief from all symptoms can be obtained by passing sounds through the esophagus into the stomach, over a previously swallowed silk thread. When cicatricial stricture is present, a No. 45 French sound can usually be passed without difficulty. Relief from symptoms usually occurs at once, although in 2 of our patients complete obstruction of the esophagus was noted for twenty-four hours after the passage of the dilating sound, with subsequent relief from dysphagia. Occasionally, the passage of sounds must be repeated at irregular intervals to maintain normal deglutition. When dysphagia is the result of spasm of the esophagus, the passage of a No. 60 French sound is usually required in order to give relief. Neither a No. 45 nor a No. 60 French sound can be passed through an esophagoscope, and smaller sounds seldom provide relief from symptoms; therefore, satisfactory dilation cannot be accomplished through an esophagoscope.

Local application of solutions, such as silver nitrate, has been recommended for treatment of ulceration that frequently occurs at the junction of the esophagus and the stomach. This treatment, however, not only is unnecessary but seldom promotes healing. When stagnation of food is prevented by adequate dilation, the ulceration will heal spontaneously.

We have not observed serious bleeding after the passage of dilating sounds, and in patients in whom spontaneous bleeding has occurred, it has proved safe to pass sounds within a week after hemorrhage has ceased.

In patients with paraesophageal diaphragmatic hernia operative repair has provided relief from symptoms, with a relatively low mortality. However, this type of hernia is occasionally associated with stricture in the lower portion of the esophagus, and operation should not be undertaken, especially when dysphagia is a symptom, until esophagoscopy has demonstrated a normal esophageal lumen. In case of stricture repeated stretching of the area of narrowing is required to restore normal deglutition. Many patients with paraesophageal hernia, experience considerable dysphagia, and seemingly the obstruction to food results from spasm or from pressure on the lower portion of the esophagus. In such patients relief from difficulty in swallowing is accomplished by passage of a No. 60 French sound. When, because of the mildness of symptoms or the unsatisfactory condition of the patient, operation is not indicated, amelioration of flatulence may be induced by the use of a type of bed that will permit rest in the semi-erect position. Reduction in the amount of food taken at mealtime, with more frequent feedings, may also diminish the sensation of fullness that frequently follows ordinary meals. Pain may be severe enough to require sedative drugs, but both pain and dysphagia are usually benefited by passage of sounds through the esophagus.

SUMMARY

Herniation of the stomach through the esophageal hiatus in the diaphragm is a relatively frequent lesion.

We have observed 59 patients with this abnormality during the past six and one-half years, and the symptoms of 57 of them are analyzed.

Pain, dysphagia and flatulence are the most frequent symptoms, with bleeding and dyspnea occurring less often.

Operative repair is seldom indicated in the so-called short esophagus type of hernia. When dysphagia is a prominent symptom, relief can be obtained by passage of dilating sounds into the stomach over a previously swallowed silk thread.

Paraesophageal hernia can be repaired by operation, with satisfactory functional results. However, not all patients with this type of hernia require operation; many may be made comfortable by passage of esophageal sounds, by regulation of the diet and activities and by assumption of the semi-erect position in sleeping.

The esophagus should be investigated carefully before operation is undertaken for any type of herniation through the esophageal hiatus in the diaphragm.

DIAGNOSIS AND TREATMENT OF GALLBLADDER DISEASE *

By HU C. MYERS, M. D.
Philippi, West Virginia

GALLBLADDER DISEASE is an ambiguous term which is frequently used to designate a group of morbid conditions of the gallbladder. It is not a clinical entity and should not be treated as such. Correct therapy for this group of diseases cannot be decided upon until a more specific diagnosis has been made. The methods for making a precise diagnosis, besides the history and physical examination, are cholecystography and diagnostic duodenal drainage. These procedures have been available for several years, but their combined values have been properly appreciated and applied only recently. Some of the findings are still confusing, and investigators remain divided in their opinions regarding certain interpretations which have been applied to the results of these laboratory and x-ray examinations. It is with the hope of showing how these data can be used in a practical way that this paper is presented. The conclusions are drawn from a study by our group of over 800 diagnostic duodenal drainages and 1,300 roentgenographic studies of patients with disease or suspected disorders of the biliary tract during the past seven years. We have learned to depend upon these two examinations for the data necessary to make a definite diagnosis and we feel that, except in a very few cases, the investigation is not complete without both of these studies. An extensive review of the literature is not the purpose of this paper. It should be mentioned, however, that Lyon and Ivy were outstanding in the development and application of diagnostic duodenal drainage; Graham and Cole originated and applied cholecystography; and Carter and his associates correlated the facts which lead to the identification of the various types of dysfunction of the gallbladder.

THE AUTHOR

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Exclusive of the neoplasms and other rare diseases of the gallbladder, there are three main surgical groups, namely, cholelithiasis, acute cholecystitis, and chronic cholecystitis. There are, also, three medical groups: the hypotonic gallbladder, the hypertonic type associated with gastric hyperacidity, and the hypertonic reflex type.

The first and most common disease of the gallbladder is cholelithiasis. Gallstones are quite common and are thought to result from

* Presented before the Monongalia County Medical Society, at Morgantown, November 2, 1943.

stasis, infection, and disorders of metabolism. They rarely occur in children and only fairly frequently in men. Calculi are most commonly found in women of middle age. They often form during pregnancy and, depending on several factors, may or may not give rise to symptoms. Usually there is gastric distress after food, intolerance to fats, pain in the right upper quadrant, and characteristic attacks of colic. While the symptoms produced by gallstones may be so outstanding as to make the diagnosis perfectly plain, still certain types of disturbed function in which there is spasm of the sphincter of Oddi may produce colic, digestive disturbances, and even jaundice. For this reason, cholecystography and duodenal drainage should usually be employed to prove the existence of stones before a recommendation for operative intervention is given.

ACUTE CHOLECYSTITIS

So-called silent calculi may remain in the gallbladder for years giving very little discomfort. Eventually, however, because of irritation of the gallbladder mucosa from the constant pressure and friction of the stones, an acute cholecystitis may supervene and the resulting cellulitis of the gallbladder wall then quite forcibly brings the disease to the patient's attention. Other complications, such as carcinoma of the gallbladder, or expulsion of one or more of the stones into the common duct with the development of obstructive jaundice, may result. Because of the fact that these complications are likely to occur, it is now generally recognized that cholelithiasis should be treated by surgery. Operation should be performed within a reasonably short time after a positive diagnosis has been made. The present accepted measure is cholecystectomy rather than cholecystostomy, although occasionally the latter procedure has a place in the treatment of calculus disease.

The diagnosis of acute cholecystitis can usually be made without extensive laboratory or x-ray examinations. The history of acute and persistent pain in the right upper quadrant, nausea and vomiting, leucocytosis, elevation of temperature, with abdominal tenderness and rigidity over the gallbladder region are so characteristic that it can hardly be confused with any other disease. The type of treatment which the surgeon should employ will depend on his experience. Formerly, we treated these cases expectantly and operated upon them at a later date. During the past five years, however, we have almost routinely advised cholecystectomy within twelve to twenty-four hours after the diagnosis has been made. This lapse of time is for the purpose of reestablishing fluid and electrolyte balance and the administration of glucose. Operation may be technically difficult, but if the gallbladder is dissected free from its bed before the cystic duct is ligated, usually the procedure will be more simple than operation performed after the adhesions have had time to become firm and edema has subsided.

DIAGNOSIS

The last surgical condition which will be discussed is chronic cholecystitis. There has been much confusion among investigators as to what should and what should not be called chronic cholecystitis. The recent trend seems to be to place in this category only those cases which have a definite fibrosis of the gallbladder wall with an infiltration of lymphocytes and other inflammatory cells, perhaps a partial loss of the gallbladder mucosa, and with dense adhesions about the gallbladder and cystic duct. These morbid changes are practically always the result of and follow an acute cholecystitis which has not been treated by cholecystectomy. Approximately 90 per cent of them are associated with calculi. There is often a contraction of the gallbladder with complete loss of its elastic properties and so much damage to the mucosa that its function of concentrating bile is destroyed.

The history will reveal one or more previous attacks of acute cholecystitis. There will be tenderness at Mayo-Robson's point. Cholecystography may show a complete fail-

ure of visualization of the gallbladder because of an obstruction of the cystic duct from an impacted stone, or there may be a light shadow from failure of the mucosa to concentrate the dye. Radiopaque or radioparent shadows may be present representing gallstones. The duodenal drainage yields only a light colored bile with pus cells, mucus, and epithelial cells which are bile stained, and very rarely cholesterin crystals, and calcium bilirubin pigment.

TREATMENT OF CHRONIC CHOLECYSTITIS

The treatment for chronic cholecystitis of this well-defined variety is surgical. Operation is often very difficult since there is usually extensive fibrosis about the cystic and common ducts, and extensive peritoneal adhesions about the whole area. At times there is stasis in the common duct resulting from the fibrosis or from stones which have been extruded into the common duct from the gallbladder. If there has been jaundice, or if a contracted gallbladder is found, or any suspicious nodules along the course of the common, hepatic, or bile ducts, the common duct should be opened and a thorough exploration carried out before the gallbladder is removed. In most of these cases, it will be found safer to remove the gallbladder starting at the fundus and dissecting toward the cystic duct rather than using the conventional retrograde method. At times, because of the extensive fibrosis between the cystic and the hepatic ducts, a cholecystectomy is not feasible. In such a case, a less hazardous procedure is to remove the anterior half of the gallbladder, coagulate the remaining mucosa with a high frequency electrode or actual cautery, and suture the remaining gallbladder wall together over the coagulated area.

True chronic cholecystitis may produce some of the most difficult problems with which the abdominal surgeon has to deal. There is no doubt that prevention of this disease by the early removal of the calculous gallbladder will prevent the high morbidity and mortality which accompany surgery for this condition.

Disorders of the filling and emptying mechanism of the gallbladder comprise a large portion of the gallbladder diseases which give rise to symptoms. This group is composed of those cases which have a loss of tone of the gallbladder musculature with resultant lack of emptying power and, also, those cases in which there is a spasm of the common duct sphincter (sphincter of Oddi) with consequent damming of bile in the common and hepatic ducts and the gallbladder. These cases require medical management. Surgery not only fails to give relief, but often will actually make the symptoms more severe.

CASES REQUIRING MEDICAL MANAGEMENT

Atonicity of the gallbladder occurs quite frequently and seems to be associated with atonic conditions of other organs, such as an atonic colon. It is usually found in individuals who have a low gastric acidity. The patient gives a history of distress in the right upper quadrant most marked between meals or during fasting. The diagnosis is made by finding a large, rounded gallbladder shadow on the cholecystogram, with delayed filling and emptying. With diagnostic duodenal drainage, the gallbladder usually fails to empty when stimulated by magnesium sulphate solution, but empties well when olive oil is injected into the duodenum. There may be crystals or calcium bilirubin pigment in the bile, and at times a few pus cells. Gastric analysis shows a hypoacidity. The treatment consists of giving a diet rich in fats, olive oil between meals, and large doses of hydrochloric acid during and after meals. Surgery is not indicated.

The second type of dysfunction is the hypertonic gallbladder associated with hyperacidity. In this condition, there is a spasm of the duodenal musculature and the sphincter of Oddi. The gallbladder walls are thickened and the gallbladder is enlarged. The patient gives a history of colic, digestive disturbances, and sometimes jaundice. The x-ray study reveals an enlarged gallbladder with poor filling and emptying. With duodenal drain-

age, a poor response to magnesium sulphate is noted, but there is fairly good response to olive oil. Gastric analysis shows a hyperacidity. The treatment of this condition is frequent feedings with an ulcer type diet, alkalies, and antispasmodics, such as belladonna.

HYPERTONIC REFLEX GALLBLADDER

The third type of disordered function is the hypertonic reflex gallbladder. This, likewise, is associated with spasm of the sphincter of Oddi. There is hypertrophy of the walls and enlargement of the gallbladder. The spasm in these cases is due either to reflex stimulation from some other abdominal condition, such as a fecalith in the appendix, or from excessive vagal stimulation because of a neurosis or other disease of the central nervous system. Roentgenograms in such a case show a large gallbladder with poor filling and emptying. With duodenal drainage, there is a good response to magnesium sulphate. The treatment of this condition is removal of the source of reflex irritation, mental rest, sedatives, saline cathartics, and antispasmodics.

I do not want to leave the impression that the pathology or disturbed physiology which is present can be definitely determined in every case of gallbladder disease. Even with a complete study which has been repeated two or three times, the exact condition may sometimes remain in doubt. It is then that the physician's clinical judgment based on his experience must be brought into play, and the type of treatment applied which he thinks is best. In most cases, however, with an adequate study, a definite diagnosis can be made and the internist or surgeon can carry through the necessary treatment with a confidence which was unattainable without cholecystography and diagnostic duodenal drainage.

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CANCER REMEDIES

Even in the midst of war, purported cancer remedies continue to appear. The most recent flurry is concerned with an English preparation known as "H 11." This is an extract of urine that is supposed to have tumor-inhibiting properties. As usual, the earlier reports appeared promising but the later give little, if any, hope that the substance is of value.

The material, prepared by Thompson,[1 2] has been utilized by several groups for therapy of both human cancer and induced as well as spontaneous transplantable cancer in animals.[3 4] In one series of 51 advanced cases of cancer, 37 cases received dosages that might be regarded as sufficient for fair clinical trial.[5] Among these, 11 died and the results were unknown in 5 cases. The longest period of survival was eighteen months. All the patients surviving except two (who lacked biopsy proof of the presence of cancer) had some other form of therapy in addition to H 11. In none of the cases in which H 11 was used did the growth disappear. There was a suggestion of slight clinical improvement in some cases, but this has often proved to be misleading in evaluating remedies.

The evidence seems to indicate that this urinary extract is without value as a therapeutic agent in cancer.

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100,000 SOLDIER-STUDENTS

More than 100,000 soldiers are now studying at colleges and universities under the Army specialized training program. The goal is 150,000 soldier-students.—*West Virginia School Journal.*

Tuberculosis Abstracts

Furnished Through the Courtesy of the West Virginia Tuberculosis Association

This is the time of year when the commoner communicable diseases are apt to dominate the medical scene. Johnny breaks out with a rash; Mary has a suspicious parotid swelling; Jimmy's throat is red and sore; Dad has a chest cold that will bear watching for possible pneumonia. Suddenly these troubles bubble up; furiously they boil; generally they cool with equal rapidity. But there is one common communicable disease that seldom flaunts a rash, that does not start with a high fever, that fails to herald its approach by means of sore throat, overwhelming malaise, violent headache or major digestive upset. That disease is tuberculosis, and the time of the year to watch out for it is exactly twelve months long!

Seasonal Maladies

In combating the spread of communicable diseases, the isolation of the case throughout the period of marked infectivity is of considerable importance. At best, however, this can be only partially accomplished, for the period of infectivity so often begins hours or days before symptoms sufficiently manifest themselves to make possible a diagnosis. Mild subclinical infections go undiagnosed, yet serve to spread infection to others. Obviously, with such initial gaps in isolation procedure, we can hope to gain but little by being hypermeticulous in carrying out the latter part of the isolation process. The effort should be twofold: (a) to prevent, as far as practicable, the spread of infection to others; (b) to keep the time lost by the case in isolation at a minimum.

With this double objective in mind, we should avoid on the one hand, such lax regulations as would permit German measles cases to carry on their regular duties and contacts in the obvious presence of rash and swollen postcervical lymph nodes, and on the other hand, such strict regulations as would keep scarlet fever patients routinely under isolation for six weeks or more. A well-balanced communicable disease control program will endeavor to isolate suspected cases promptly and freely; will release them just as promptly when observation shows the suspicion unfounded; and will extend the isolation only through the definitely and dangerously infective period.

Recommended isolation periods for the more common communicable diseases are as follows: (Note—These are Navy suggestions. Physicians will know whether or not they conform to local health regulations.—Ed.)

Measles.—Communicable from the onset of the catarrhal symptoms (usually at least three days before the appearance of the rash) until the catarrhal symptoms have ceased (usually shortly after the return of the temperature to normal and well before the rash has completely disappeared). In a case without complications or abnormal discharges, release from isolation is usually safe any time after the fifth day following the appearance of the rash, provided the catarrhal symptoms have ceased.

Mumps.—Communicable from 24 hours preceding the appearance of symptoms until the subsidence of all swelling in salivary glands or involved testicles. Release from isolation is usually safe 24 hours after all swellings of salivary glands or testicles have subsided. (It should be remembered, however, that with adult males the chance of orchitis persists for about one week after the subsidence of the parotitis.)

Rubella (German Measles)—Apparently communicable from 24 hours preceding the appearance of the rash unitl the subsidence of the rash. Release from isolation is usually safe 24 hours after the disappearance of the rash.

Scarlet Fever, Streptococcic Pharyngitis, Streptococcic Tonsilitis.—Most communicable in the first two weeks of the illness, communicable in the third week in approximately 25 per cent of cases, communicable in the fourth week in approximately 5 per cent of cases, communicable after the fourth week in approximately 1 per cent of cases, Release from isolation is usually safe 21 days after the onset of the disease, provided there are no complications or discharges. For another three weeks after release from isolation the patient should consider his nose and throat secretions still possibly dangerous to others. Desquamation has no relation to communicability.

Chickenpox.—Infectious from 24 hours preceding the appearance of the eruption until there are no longer any actual pustules. Release from isolation is usually safe when all pustules are gone (usually about seven days from onset), and the patient has taken a thorough bath and shampoo.

(Continued on page xxxi)

The President's Page

Another month—another page. Life goes on but the brain (?) grows numb. What with the flu, women with low back pain, and a host of other ailments, there seems so little time for thoughts ethereal.

To be sure, we still have problems, the most vital of which is Senate Bill 1161, but we do not seem to be particularly concerned. Oh, yes, we discuss it occasionally with friends. We skim through pamphlets that are sent to us. We do not like it, but being interested primarily in the "healing art", we are inclined to let others do our worrying and our conniving for us. Perhaps it is just as well. We are a gentle lot, except when it comes to bickering among ourselves, and in this latter art we have no equal.

We have bickered for years over plans for prepaid hospitalization and medical care. In some places the bickering ceased, plans were adopted, and in the majority of cases everyone seemed happy. But in other communities the bickering continued, no conclusions could be reached, no plans were adopted, and another finger of scorn was pointed in our direction. Out of this confusion arose the flames that kindled S. 1161; so out of the wells and rivers of justice must come the waters to extinguish the flame. Not by federal control, not by political bureaucrats, but by the united efforts of the medical profession and hospital boards, giving their best services to the low income group at a minimum rate, on a prepayment basis, with free choice of physician and hospital. We know this. We want this. Then, for heaven's sake, let's do it.

In the meantime, this bill may come out of committee, this bill may soon come to a vote, this bill may pass. Will you be one who sat idly by and did nothing? Or do you by chance approve this bill, and believe that in its passage lies the future salvation of the wage earner and the medical profession. If so, speak up; maybe we who disapprove are wrong. Whatever you believe, say it. Tell your friends, tell your patients, cry it from the housetops if you like; but, whatever you think, say something.

I, for one, can not believe that this country, through its representatives, is about to scrap the past 168 years. And so, let us not be like the proud gladiators of ancient Rome who were heard to say as they stood in the arena, "We who are about to die, salute you."

President.

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MALE CLIMACTERIC

During the past few years the expression "male climacteric" has been noted with increasing frequency in medical writings and in medical conversations. The exact meaning of the term has yet to be given. In women the climacteric presumably denotes the cessation of menstruation with its attendant physiological and psychological symptoms resulting from endocrine changes. In the male no such hormonal changes have been established. This statement will hold in spite of the fact that men in the late forties, fifties and sixties may show a slight increase in gonadotropic hormonal excretion. However, the change is rarely as abrupt in men as it is in women. The diagnosis in men seems to rest upon a combination of symptoms which most urologists of experience have long associated with prostatic congestion and impotence, occurring at any time during the period of active sex life and responding to the usual course of prostatic massage, posterior urethral instillations and regulation of the sexual life.

We have awaited the word of the man of experience who will demonstrate that the so-called male climacteric occurs mostly in men of sedentary occupation who carry business responsibilities, who take little exercise, who go home tired from exhausting days of mental effort to wives in the menopausal age with decreasing libido, who decide in the face of these circumstances that intercourse is all nonsense anyway and remain continent. Ultimately, the results of premature continence, lack of exercise and being in a physical and emotional rut exact the price: lassitude, backache, inabiltiy to concentrate, etc.—the clinical picture of the so-called male climacteric.

Before the days when hormone manufacturers were teaching the medical profession clinical medicine, such conditions responded well to treatment directed toward establishing normal lives. Today, at best, the drug manufacturers can promise improvement only while their high-priced preparations are being administered. Beyond all this one wonders as to the advisability of artificially increasing the amount of testosterone in the bodies of patients at this age. Very remarkable results have ensued in the presence of carcinoma of the prostate from diminishing in every way possible the production of testosterone.

DUES PAYABLE

Officers of several component societies have already remitted for State Association dues paid by members for 1944. Dues are payable January first, and the work of local secretaries and treasurers would be lightened considerably and much extra bookkeeping avoided if payments were made promptly so that remittances of dues of all members could be included in one or two letters to the headquarters office at Charleston.

There is no special assessment for 1944. The assessment of $10, levied by the House of Delegates in 1942 to meet the deficit occasioned principally by the non-assessment of dues against members in the military service, was effective only for 1943.

At the time of the annual meeting at Charleston last year, fourteen component societies were over the top in the payment of

dues by members. We do not believe that it is too much to hope that all component societies may be able to report a one hundred per cent collection of dues before the annual meeting at Wheeling in May, 1944.

LOCAL MEDICAL HISTORY

In an interesting address delivered before the Kanawha Medical Society at the annual meeting in Charleston early in January, Dr. Roy Bird Cook, immediate past president of the American Pharmaceutical Association, and historian with an almost unbelievable store of knowledge concerning West Virginia and West Virginians, traced the activities of the Society from the organization meeting down through the years to the present date.

Many items of historical value and local interest were given the guests by Dr. Cook, who even produced the minutes of the first meeting. The part doctors have played in the development of the Kanawha valley and the state, their hardships in the early days and accomplishments when drugs and instruments were insufficient at times to enable them to render adequate medical care even to a small population, combined to provide a story of intense interest to West Virginia doctors.

The speaker brought to light facts which have never appeared in print. They were obtained by him through research among the papers of doctors who have long since passed to their reward. It is hoped that the full story may be available for printing at some time in the future.

How much don't we know about the practice of medicine in the early days of our state? How valuable a contribution could be made to West Virginia medicine, to the history of our state, if each component society of the West Virginia State Medical Association were to appoint a committee of interested doctors to gather together and put in manuscript form for their archives the valuable fragmentary scraps of knowledge of life as it was lived by the doctors in the old days, some of which is still fresh in the memories of those whose lives began long before the period now known as the "Gay Nineties." Unless a real effort is made to record for posterity facts now known by but a few, it will be too late, and much data of interest to the medical profession in this state will have been lost forever.

HOSPITALIZATION NEEDS

Late in December, 1943, the Board of Trustees of the Kellogg Foundation voted a grant of $35,000 for study by the Post-War Planning Committee of the American Hospital Association of the post-war hospitalization needs of America. The worth of this project had already been recognized by a grant of the same amount from the Commonwealth Fund, contingent upon securing the balance of the $100,000 two-year budget from other sources. The Board of Trustees of the American Hospital Association has voted $15,000 this period.

While it is probably felt generally that we should first win the war and then proceed with a nation-wide extension program for hospitals, the thorough study of the problem at this time, followed by careful planning for the future, will save much precious time at the war's end.

The object of this two-year research program contemplated by the Kellogg Foundation and the American Hospital Association is two-fold. First, an effort will be made to determine the adequacy of the distribution of present hospital facilities, and, second, a proper method will be sought for providing adequate hospital care for all of our citizens. While existing data will be used, there is no doubt that it will be necessary to conduct a country-wide survey if a true and accurate picture of hospital facilities and needs is to be obtained.

In this most important study of post-war hospitalization needs, representatives of the American Medical Association, or of the proper Association committee, should partici-

pate. No professional or business men in the country are better qualified to determine such needs now and after the war than the doctors themselves.

The Kellogg Foundation and the American Hospital Association are to be congratulated for inaugurating this program. They have unanimously agreed that the need is urgent. To complete a job that has such a good beginning, the American Medical Association should be invited to name representatives on the proposed study commission, by which the full program will be gotten under way.

ABSENTEE VOTING

Thanks to Governor Neely and the West Virginia Legislature, the 408 West Virginia doctors in the military service, no matter where stationed, will be given the opportunity to cast their votes in 1944 for every candidate on the ticket "from constable to president."

Acting promptly when the federal plan providing methods for voting by those in our armed forces bogged down in Congress, Governor Neely called a special session of the Legislature for early in January to act upon his recommendation that our laws be amended so as to enable qualified voters now in the military service to cast their ballots at the election in November. The Legislature completed its work in four days and adjourned.

Under the new law, the deadline for filing as a candidate for office is advanced to February 5. This provision will enable those in the military service to participate in the primary as well as in the general election.

West Virginia has the honor of being the second state to enact laws to extend voting privileges to those who are serving in our armed forces at home and abroad. A similar law was enacted by Georgia just a few hours before Governor Neely signed the West Virginia bill.

We congratulate the Governor and the Legislature for acting promptly to provide means whereby all of the many thousands of West Virginia voters in the military service may be able to cast their votes at the election in November.

MALDISTRIBUTION OF DOCTORS

The maldistribution of physicians during the next few years, indicated in a survey made recently by two officers of the United States Public Health Service, need not necessarily require a revolution in medical education or practice for its correction, *The Journal of the American Medical Association* for January 15 says, adding that improved hospital and laboratory facilities may produce the desired salutary effect. *The Journal* says:

"The effect of the war on the distribution of physicians has recently been discussed by G. St. J. Perrott and B. M. Davis. These investigators of the United States Public Health Service report a survey of the changes in the medical manpower picture. Moreover, they attempt an estimate of the changes to take place during the next few years.

"The war has withdrawn about one-third of the active practitioners of medicine in the United States. The rate of decrease in the number of civilian physicians from Jan. 1, 1942 to the present time has been precipitous. There were more than 130,000 active private practitioners on Jan. 1, 1942; there will be only about 85,000 at the end of 1943. The recruiting of practicing physicians has already diminished greatly; the armed forces will obtain additional medical officers from among the graduating medical students. The services expect to take 80 per cent of all medical graduates; the number entering civilian practice will no longer fully replace those who die or retire. Consequently Perrott and Davis predict an annual net loss of about 2,100 for the period following Jan. 1, 1944.

"The rate of attrition, the authors predict, will tend to be most severe in the states which were medically poor before the war; these states generally have a high proportion of older graduates and receive an unduly low

proportion of new medical graduates. New York, with about 10 per cent of the country's population, receives nearly 18 per cent of the new physicians; Alabama, with about 2 per cent of the population, receives but one-third of 1 per cent. Twenty-eight states with a combined population of 54,500,000 are expected to have more than 1,500 persons per physician by Jan. 1, 1944, and seven of these states, with 13,500,000 population, will have more than 2,000. During the past twenty years there has been a trend for the states rich in physicians to become richer and for the states poor in physicians to become poorer, largely because of the preference of new graduates to locate in the states which most encourage medical practice.

"The analysis by these officers of the United States Public Health Service serves to indicate certain aspects of the distribution of physicians, to which attention may well be directed in postwar planning for medical services. The situation described need not necessarily demand a revolution in medical education or medical practice for its correction. Improvement in the supply of hospital and laboratory facilities may promptly have a salutary effect."

WEST VIRGINIA READY

West Virginia has spoken on the Wagner-Murray bill. Letters from members of the West Virginia delegation in Congress reproduced in this issue of THE JOURNAL merit careful study on the part of all doctors in this state. In these letters will be found an open and frank discussion of the reasons why the writers oppose the passage of the bill.

It might be suggested that doctors who reside in districts represented by congressmen who not only see the danger of this bill, but are willing to do something about it, write letters to their congressmen expressing approval of their stand and appreciation of their announced intention to stand up and fight if and when the bill comes out of committee.

Even though there has not been much stir lately within Congress itself concerning the plan to amend the social security act, the bill is by no means dead. It is being permitted to slumber quietly in committee. It is comforting to know that our representatives on the congressional front are prepared to meet this challenge when the fight is carried to the floor of the House.

A.P.O. AND FLEET P.O. ADDRESSES

The following is a list of Army and Fleet post office addresses of West Virginia doctors in the military service received at the headquarters office of the State Medical Association since the last issue of THE JOURNAL:

Lt. Willard Pushkin, MC,
APO 824,
c/o Postmaster, New York, N. Y.
Captain Richard Hamilton, MC,
APO 38,
c/o Postmaster, San Francisco, Cal.
Lt. Comdr. F. H. Dobbs (MC), USNR,
M.A.G. 13,
c/o Fleet P. O., San Francisco, Cal.
Lt. A. J. Villani (MC), USNR,
c/o Fleet P. O.,
San Francisco, Cal.
Capt. C. L. Houck,
APO 489,
c/o Postmaster, New York, N. Y.
Capt. Joseph Gilman,
APO 782,
c/o Postmaster, New York, N. Y.
Major Arnold Wilson,
APO 578,
c/o Postmaster, New York, N. Y.
Lt. Col. Bert Bradford,
APO 230,
c/o Postmaster, New York, N. Y.
Lt. John R. Godbey (MC), USNR,
Hy. Co., 2nd Bn., 5th Marines,
c/o Fleet P. O., San Francisco, Cal.

MEDICAL DIRECTOR APPOINTED

The State Health Department has been notified by Surgeon General Thomas Parran, of the United States Public Health Service, of the appointment of Dr. R. D. Wright, former venereal disease consultant attached to the North Carolina State Department of Health, as medical officer in charge of the new Kanawha Valley medical center at South Charleston.

The center, established by act of the 1943 legislature, will be used for the treatment of venereal disease cases. It is located in the building formerly used as an NYA training school.

General News

WEST VIRGINIA VOTERS IN MILITARY SERVICE TO CAST BALLOTS IN 1944

In a special session of the legislature which lasted from January 3 to January 7, 1944, the absent voter's law was amended so as to permit any qualified voter who is a member of any branch of the armed forces of the United States, whether within or without the territorial limits of the United States, to vote at all primary and general elections in West Virginia until 1947.

If any person entitled to vote is not registered under the provisions of the general law, he may apply to the clerk of the county court of his home county for temporary registration, using a simplified form to be furnished by the court. Requests for this form may be made by mail or otherwise by the applicant himself or by any other person. The application must be certified by a commissioned officer, warrant officer, or noncommissioned officer no lower in rank than a sergeant, or the equivalent Navy rating, or by some other person qualified to administer oaths. The certificate need not state the place where it is made and no seal is necessary.

If the applicant has filled in that part of the form requesting an absent voter's ballot, the clerk of the county court will immediately transmit the request to the clerk of the circuit court.

If the request for the ballot is made by the voter himself, it may be made informally by mail or otherwise. But if made by any other person it must be upon a printed form to be filed by the person making the request.

Upon receipt of the ballot for primary or general election, the voter, after marking it, will seal it in the envelope furnished for that purpose, execute the affidavit appearing on the back of the envelope, and send it by any available mail service to the circuit clerk who issued it.

Under the provisions of the amended law, which is effective only until June 30, 1947, all candidates must file certificates before February 5, instead of in April as provided in the old law. Ballots are returnable up to and including election day, but any received later will be invalid.

OVER 600 DOCTORS PARTICIPATING IN EMIC PROGRAM IN WEST VIRGINIA

Since the start of the Emergency Maternal and Infant Care Program on May 12, 1943, 3,080 applications have been approved by the Director of the Division of Maternal and Child Hygiene of the West Virginia State Health Department. Of this number, 131 applications were for the treatment of children under one year of age.

According to Dr. Lenore Patrick Chipman, Director of the Division, 59 hospitals and over 600 doctors are now participating in the program. After complimenting the doctors and hospitals for their cooperation in the work of the division, Dr. Chipman emphasized the importance of the following ten points in connection with the E.M.I.C. program in West Virginia:

1. Under this program, wives of enlisted men are entitled to medical, nursing, and hospital care, as needed and available, throughout pregnancy, at childbirth, and for six weeks thereafter.

2. Infants of enlisted men are also entitled to medical, nursing, and hospital care, as needed and available, until they are one year old.

3. The care involves no expense for the enlisted man or his wife. Payment for services is made by the State Health Department directly to doctors and hospitals. Payments to the doctor or hospital, in addition to those made by the State Health Department, may not be made by or on behalf of the wife. Hospitals are paid on the basis of the cost of ward care, whether the wife or baby is cared for in a ward or in other accommodations.

4. No period of residence in a state is required. Race or color does not matter.

5. The wife may apply for maternity care as soon as she knows she is pregnant, and for care for her baby at any time.

6. The wife fills out an application form which she gets from her doctor, a hospital, a clinic, the local health department, a Red Cross Chapter, or the State Health Department. Separate forms must be filled out for maternity care and for infant care.

7. The doctor who is to give care signs the application. It must be forwarded by the wife or doctor to the State Health Department immediately since payment for care can be considered by the State Health Department only after the application has been received. The wife and her doctor will be notified when the application is approved.

8. Payment cannot be expected for medical or hospital services which the wife or infant has had before application is made.

9. Services of a consulting physician, as needed and available, may be provided under the program.

10. For the protection of mothers and babies, each state health department has certain standards which doctors and hospitals providing care must meet.

RELOCATION FUND FOR DOCTORS AND DENTISTS CUT TO $200,000

The first supplemental national defense appropriation bill, 1944, which was introduced in the House of Representatives, November 4, 1943, was passed by the House just before the Christmas holidays, with a Senate amendment providing for the appropriation of $200,000 for the relocation of doctors and dentists for service in states in need of additional medical and dental care. The supplemental estimate originally submitted by the President to Congress provided for the appropriation of $4,427,550, of which amount $1,000,000 was earmarked for this purpose.

The compromise reached by the conference committee was accepted by both the Senate and House, and the bill has been signed by the President.

In the debate preceding the passage of the bill by the Senate on December 8, by a 43-20 vote, Senator W. Chapman Revercomb of West Virginia precipitated a wide-open discussion of socialized medicine. Opposing the bill on the ground that it smacks too much of state medicine or state controlled medicine, Senator Revercomb said:

"Upon application of any community in this country which might want a doctor, the Government would pay a doctor a monthly salary, would pay his travel expenses, and would establish him in a new community. By whatever name that might be called, whether it be called socialized medicine or State controlled medicine or State aid to doctors, it seems to me the provision is not a good one. There are several matters at which we may look, several viewpoints to be taken, in connection with the proposal. The first is that the Government is beginning to pay doctors, to send them out into the communities of the country, which is something entirely new.

"The Government would be going into the business, upon the application of various communities, of sending a doctor to each of such communities, and of paying his expenses for 3 months. We may call that a temporary thing, if we desire to do so; but we know that if the doctor goes there and begins the practice of medicine, there is at least a possibility that he will stay there.

"It has been said that the real cause for the shortage of doctors is the fact that many doctors have entered the armed services. They have. If there is one group of men to whom the people of the country owe the highest tribute, it is the doctors who have left their private practices and have entered the service, both in the Army, the Navy, and the Marine Corps. Those men—and I know many of them—without being compelled to do so, but simply in order to answer a call of their country, left their private practices, left their families, and went into the service. Some day they will want to return. When they return, they will find established there doctors whom the Government sent there while they were away performing their service to their country.

"Mr. President, I do not say that that is any reason, during this interim of the war for depriving people in need of medical attention of the medical attention they need; but I do say it would be a great wrong to the men of the medical profession who have gone into the service —and there is no higher calling in life, no calling of higher service, no men who have been more unselfish in this war—to ask the Government behind their backs to send in doctors to take their places, and to establish them there. From that viewpoint, I think the proposal is wrong."

The bill, in substance, authorizes the Surgeon General, upon the application of a municipality, county, or local subdivision of government, approved by the State Health Department, to enter into agreements with practicing physicians and dentists, under which, in consideration of the payment to them of a relocation allowance of a sum not to exceed $250 per month for three months and the actual cost of travel and transportation of the physician or dentist and his family and household effects to the new location, such physician or dentist will agree to engage in practice in such area for a period of not less than one year.

It was specifically provided by the conference committee that the relocated physician or dentist must obtain a license to practice in the state to which he moves. The bill also provides that the local community affected is to contribute 25 per cent of the total cost of the relocation allowance, travel and transportation costs of the physician or dentist and his family.

DOCTORS LICENSED BY RECIPROCITY

At a meeting of the Public Health Council, held at Charleston, January 3-5, 1944, the following applicants were licensed by reciprocity to practice medicine in West Virginia:

Harvey Meade Perkins, John H. Rentchler and Forrest L. Blair, of Parkersburg; Joseph P. Seltzer, of Charleston; John J. Lawless, of White Sulphur Springs; and, William P. Boger, Jr., of Bluefield. Nine other applicants participated in the examination conducted by the Council, the results of which will be known early in February.

The next meeting of the Council will be held at Charleston, May 1-3, 1944.

1944 RED CROSS WAR FUND

During March the American Red Cross will raise its 1944 war fund. A goal of $200,000,000 has been set. This must be met if the Red Cross is to continue its work on an undiminished scale. Let's give.

PETITION AGAIN REFUSED FOR WRIT OF MANDAMUS AGAINST PHC

The Supreme Court of Appeals of West Virginia has for the second time refused the petition of Dr. Earl C. Hahn, osteopathic physician of St. Marys, for a writ of mandamus compelling the public health council to approve the recommendation of the county court of Pleasants county and appoint him health officer for that county. The petition was refused January 7, 1944, by a 3-2 decision of the court.

In the original petition, filed November 30, 1943, which was also refused by a 3-2 decision of the court, Dr. Hahn set up the fact that he is engaged in the practice of his profession at St. Marys and that he was recommended by the county court of Pleasants county for appointment as county health officer for the unexpired term ending December 31, 1944, and that subsequently the public health council unanimously refused to make the appointment. He charged that the sole reason the appointment was not made was that he is a doctor of osteopathy and not a doctor of medicine.

Dr. Hahn averred that, as a duly licensed osteopathic physician and surgeon he is a "legally qualified physician" within the purview of Chapter 16, Article 1, Section 1, of the Code, and as such entitled to appointment as county health officer, and that the action of the public health council in refusing to make the appointment was "arbitrary, capricious, discriminatory, prejudicial and contrary to the statutes of the state."

In a supplemental petition filed December 7, 1943, there was incorporated a copy of a letter from Dr. J. E. Offner, state health commissioner, which was written in reply to a request from Dr. Hahn for an opinion concerning the policies of the public health council. In his letter, Dr. Offner is reported as having said that under the policies of the public health council, health officers must have the same qualifications as graduates of class A medical schools and must be otherwise qualified to be licensed to practice medicine in West Virginia.

Dr. Hahn claimed that, notwithstanding the fact that one of the duties of the public health council is to "define the qualifications of local health authorities and directors of divisions, and discharge other like duties," it cannot promulgate rules and regulations or make definitions which are contrary to law. He further charged that it is provided in Chapter 30, Article 4, Section 10 of the Code, that osteopathic physicians and surgeons licensed in this state shall have the same rights as physicians and surgeons of other schools of medicine, and that any rule or regulation or definition which deprives him of rights granted to physicians and surgeons of other schools of medicine is void and contrary to law.

CONGRESS SETS UP RELOCATION FUND

The first supplemental national defense appropriation bill, 1944, which was introduced in the House of Representatives, November 4, 1943, was passed by the House just before the Christmas holidays, with a Senate amendment providing for the appropriation of $200,000 for the relocation of doctors and dentists for service in states in need of additional medical and dental care. The supplemental estimate originally submitted by the President to Congress provided for the appropriation of $4,427,550, of which amount $1,000,000 was earmarked for this purpose.

The compromise reached by the conference committee was accepted by both the Senate and House, and the bill has been signed by the President.

The bill, in substance, authorizes the Surgeon General, upon the application of a municipality, county, or local subdivision of government, approved by the State Health Department, to enter into agreements with practicing physicians and dentists, under which, in consideration of the payment to them of a relocation allowance of a sum not to exceed $250 per month for three months and the actual cost of travel and transportation of the physician or dentist and his family and household effects to the new location, such physician or dentist will agree to engage in practice in such area for a period or not less than one year.

It was specifically provided by the conference committee that the relocated physician or dentist must obtain a license to practice in the state to which he moves. The bill also provides that the local community affected is to contribute 25 per cent of the total cost of the relocation allowance, travel and transportation costs of the physician or dentist and his family.

NEW HEALTH OFFICER AT WHEELING

Dr. John W. Gilmore, of Wheeling, has been named as director of the City-County Health Department in that city to succeed Dr. A. J. Niehaus, resigned.

FIVE WEST VIRGINIA CONGRESSMEN TAKE STRONG STAND AGAINST S. 1161

West Virginia Congressmen in five of the state's six congressional districts have registered their opposition to the Wagner-Murray-Dingell bill. They are Representatives A. C. Schiffler, Jennings Randolph, E. G. Rohrbough, Hubert L. Ellis and Joe Smith, representing respectively, the first, second, third, fourth and sixth districts.

Late in December, a letter was addressed to the two United States Senators and to each of our six Congressmen, requesting an expression of views with reference to the bill (S. 1161) now pending in Congress. Replies have been received from Senator Harley M. Kilgore, and Congressmen Schiffler, Rohrbough, Ellis and Smith. While Senator Kilgore goes not commit himself, the five members of the House are outspoken in their opposition to the bill.

No reply was received from Senator W. Chapman Revercomb or Representative John Kee; however, Senator Revercomb has written letters to several doctors in which he has stated unequivocably that he is opposed not only to this bill, but to any bill under the provisions of which it is sought to socialize medicine.

The attitude of our representatives with reference to S. 1161 is of the utmost importance to the members of the State Medical Association and to the people of West Virginia. For this reason, the replies received up to press time are printed in full as follows:

United States Senate
Committee on Military Affairs
January 4, 1944

Honorable Charles Lively
West Virginia State Medical Association
Charleston, West Virginia
My dear Mr. Lively:

The measure to which your letter of the thirtieth day of December refers is not out of committee yet. In these circumstances, I prefer to see the form in which the committee approves this bill before I express an opinion on it.

Regretting my inability favorably to respond to your request in this instance, but hoping to have another opportunity to serve you and your association, I am, with kindest regards,

Most sincerely yours,

hh H. M. Kilgore.

Congress of the United States
House of Representatives
Washington, D. C.
January 3, 1944

Mr. Charles Lively
Executive Secretary
West Virginia State Medical Association
Charleston, West Virginia
Dear Mr. Lively:

I am in receipt of your letter of December 30 with reference to S. 1161 and particularly that portion of the bill that relates to the practice of medicine. My position with respect to this provision of the bill, I think, is quite clear. I vigorously opposed this proposal for a number of years and, of course, my position has not changed, as you undoubtedly know. I am a firm believer in constitutional government and the system of free American enterprise that permits the individual to develop and to contribute in accordance with his or her initiative and capacity.

The regimentation of the doctors would undoubtedly destroy incentive for exploration and discoveries. Such remedies as have been made possible during the past year are evidence of the progress made under the present system. Penicillin, sulfa drugs and their uses; the derivatives from Penicillin, such as Patulin, Penicillin B and the numerous other discoveries made within the past year would be arrested.

I sincerely hope that we can permit the medical profession to continue with its progressive course of discovering and using new and additional means of treating human ills.

I trust the foregoing clearly and satisfactorily sets forth my position with respect to this important matter.

Sincerely yours,

s m A. C. Schiffler.

* * * *

Congress of the United States
House of Representatives
Washington, D. C.
January 3, 1944

Honorable Charles Lively
Executive Secretary
West Virginia State Medical Association
Charleston, West Virginia
My dear Charles:

I appreciate your valued letter of December 30. My reply is a straightforward answer in opposition

to Senate Bill 1161. I had received scores of letters from all over the state, and I desired proper time to study provisions and implications of this proposed legislation. I have come to the definite conclusion that any worthwhile principles in the bill are negative when balanced against the damaging sections, especially as they affect the medical profession.

I have not been "on the fence" in this matter, but as stated above, I desired to become familiar with this intricate legislative proposal and, therefore, did not come to a hasty decision. In an attempt to formulate my opinion I discussed this proposal with Representative Dingell of Michigan, who is co-sponsor of the legislation with Senators Murray and Wagner.

With warmest personal regards, I am

ed Cordially yours, Jennings Randolph

* * * *

Congress of the United States
House of Representatives
Washington, D. C.
January 4, 1944

Mr. Charles Lively,
Executive Secretary,
W. Va. State Medical Association,
Charleston, West Virginia.

My dear Mr. Lively:

I have your letter of December 30th concerning the Wagner-Murray bill, S. 1161.

No adequate reason has been given me yet that convinces me that this measure should become a law. I can see no reason why the medical profession should be regimented as it seems would be the case if S. B. 1161 should be passed.

Very truly yours,

egr w E. G. Rohrbough

* * * *

Congress of the United States
House of Representatives
Washington, D. C.
January 15, 1944.

Mr. Charles Lively,
Executive Secretary,
West Virginia State Medical Association,
Charleston, W. Va.

Dear Mr. Lively:

This is in response to your invitation of December 30th to express my attitude on S. 1161, the Wagner-Murray Bill, commonly known as the "Cradle-to-the-Grave" Social Security Bill.

All of the members of the medical profession who have written to me in regard to this bill know what my attitude is, as I have expressed my opposition to this measure in no uncertain terms: that the proposed legislation is wrong in principle and is a part of a general plan on the part of the administration to bring about socialism in this country by gradual regimentation of our people.

There are many reasons for my strong opposition to this bill. It would impose a tax burden upon the American people and upon industry far in excess of their ability to pay at this critical time. For this reason, this bill is ill-timed.

It is ill-timed for another reason. A great number of the members of the medical profession are now serving in our armed forces, both here and overseas. Certainly Congress should not pass legislation which so vitally and adversely affects the rights and interests of these men and women when they are not in a position to voice their objections to it.

Enactment of this measure would set up a medical dictatorship under the Surgeon General of the United States Public Health Service which would affect the health and lives of an estimated 110,000,000 people. Members of the medical profession would be subject to complete regimentation. Private practice of medicine, as we know it, would be destroyed. New qualifications as a prerequisite for the treatment of a particular disease could, and probably would, be imposed under section 905(4) of the bill empowering the Surgeon General to designate who shall be deemed a specialist. No doubt the right to practice medicine would be lost to a great number of doctors who for some reason or another would not be able to meet the requirements imposed by the bureaucratic medical politicos.

Perhaps the most harmful effects of legislation of this nature would be the impairment of the motive for personal achievement on the part of the individual physician. Personal effort and achievement should be encouraged by such reward as it can demand without undue government restrictions. Unless this incentive is preserved in full measure, research will falter and progress in the medical field will be materially retarded. Moreover, if we place the doctor on the public payroll, the present relationship between physician and patient will be destroyed. No doctor can have a select clientele. He will attend the patients which the bureaucrats assign to him. And what is worse, no patient desiring to avail himself of the benefits of the law would

be free to select his own doctor without complying with the regulations prescribed by the Surgeon General. This is regimentation in every sense of the word.

It was Thomas Jefferson, I believe, who said: "Eternal vigilance is the price of liberty." This is as true today as it ever was. This statement was made by Jefferson at a period in our history when a high value was placed on personal liberty and freedom. It seems that for the past 150 years since this statement was made, the people have not heeded this injunction. They have slumbered upon their rights until the New Deal rudely awakened them. Thanks to the vigilance and alertness of the medical profession, it appears that this last and most brazen of all attempts to regiment the lives of the American people will be completely frustrated. The Congress has been swamped with letters of protest from doctors and nurses from all over the country. I am confident that their protests have not been in vain. S. 1161 will never receive the approval of the Congress.

I am grateful that I have been given the opportunity to express my views to a greater number of the members of the medical profession of West Virginia on this subject.

Sincerely yours,

HSE:C Hubert S. Ellis

* * * *

House of Representatives U. S.
Committee on Mines and Mining
Washington, D. C.
December 31, 1943

Honorable Charles Lively,
Executive Secretary
West Virginia State Medical Association
Charleston, West Virginia.

My dear Mr. Lively:

In regard to your letter of December 29 and my heretofore announced opposition to the Wagner-Murray Bill, S. 1161, now pending in Congress, I would repeat for publication in the West Virginia Medical Journal that I am opposed to the provision in the bill which, in my opinion, would tend to socialize the practice of medicine.

Furthermore, it is my belief that if this bill, as drafted by Senator Wagner, should become law, it would tend to disrupt and likely result in lowering the standards and recognized practices of the medical fraternity, and that instead of being helpful to the group which it proposes to benefit, it would more than likely lessen that group's opportunity for proper surgical and medical treatment.

With personal regards and best wishes for the New Year, I am

Sincerely yours,

Joe L. Smith, M. C.

NEW NURSE RECRUITMENT OFFICER

On February 1, Miss Mildred Riese, superintendent of Orthopædic Hospital, Los Angeles, will join the staff of the American Hospital Association as nurse recruitment officer to coordinate the association's activities under a contract with the United States Public Health Service for the program of the United States Cadet Nurse Corps. The National Nursing Council for War Service has the major responsibility for the recruiting program, but the nurse recruitment officer of the American Hospital Association will work with those portions of the program affecting hospitals and the hospital administrators.

Prior to becoming superintendent to Orthopædic Hospital in 1924, Miss Riese was superintendent of the North Carolina Hospital at Gastonia, N. C. A graduate of the Waltham, Massachusetts Training School for Nurses, she has a B.S. degree from Teachers College, Columbia University, with a major in hospital administration. She is a Fellow of the American College of Hospital Administrators, a member of the Association of Western Hospitals, of the American Nurses Association, and of the American Hospital Association.

ANNUAL CONFERENCE CANCELLED

By action of the Council, the 1944 Conference of Presidents and Secretaries has been cancelled. It was felt that difficulties of transportation, coupled with the acute need for doctors at home on account of the doctor shortage resulting from the absence of so many members in the military service, would render it impossible to have a satisfactory attendance. For the same reasons, the January meeting of the Council has been postponed until a later date.

SOCIAL HYGIENE DAY

February 2 will be observed not only as "Ground Hog Day," but also as "Social Hygiene Day." In programs to be given throughout the country, the eradication of venereal diseases will be stressed, together with the promotion of social protection services.

MILITARY ADDRESSES NEEDED

Information concerning the present military rank, unit and address of each of the following members in the military service is requested by the West Virginia State Medical Association:

Ashman, Hyman	Gallagher
Butterfield, D. L.	Milburn
Cardey, N. L.	Winona
Crank, G. O.	Lawton
Davis, W. W.	Beckley
Derkach, S. L.	Glen Rogers
Dickerson, L. A.	Fayetteville
Glassman, Dan	Charleston
Holmes, E. B.	Parkersburg
Jones, C. T.	Pemberton
Kroll, Peter G.	Welch
Laslie, J. C.	Charleston
Main, Emory H.	Philippi
Moore, Moore, Jr.	Beckley
Newhouse, N. H.	Charleston
Nutter, P. D.	Beckley
Pollock, B. H.	Charleston
Thomas, Wes C.	Charleston
Ward, Harold W.	Sutton
Warren, J. O.	Welch
Woodford, Thomas L.	Belington

Letters containing information concerning any of the doctors named should be addressed to West Virginia State Medical Association, Box 1031, Charleston 24, West Virginia.

WEST VIRGINIA INITIATES IN A. C. S.

During the year 1943, thirteen West Virginia doctors were accepted into fellowship in the American College of Surgeons. The following is the complete list of initiates:

Bert Bradford, Jr., Francis A. Clark, John B. Haley, George Miyakawa, and Harwood H. Ritter, Charleston; William T. Gocke, Herbert H. Haynes, and Joseph F. Lembright, Clarksburg; Joseph S. Maxwell and William A. Welton, Fairmont; Matthew M. Ralsten, Beckley; Henry J. Wiser, Bluefield; and, Donald W. Mitchell, Ronceverte.

STATE HEALTH CONFERENCE

The annual State Health Conference will be held at the Daniel Boone Hotel, Charleston, May 1-2, 1944. The program will be in charge of a committee composed of Dr. A. M. Price, director of the Kanawha County Health Department, and Miss Cecelia Robrecht, venereal disease nursing consultant, Charleston, and E. B. Carroll, sanitarian at the West Virginia Training Center, Morgantown.

Obituaries

E. H. DOUGLAS, M. D.

Dr. E. H. Douglas, of Petroleum, was born in that town on March 4, 1867. He was educated at Muskingum College and received his M. D. degree at Bellevue Hospital Medical College in 1894, being licensed to practice in West Virginia the same year. With the exception of a few months during which he practiced in Taylorville, Illinois, he had practiced continuously at Petroleum. He was an honorary member of the West Virginia State Medical Association, the Academy of Medicine of Parkersburg, and the American Medical Association.

Dr. Douglas died December 28, 1943, of anemia.

RELOCATIONS

Dr. J. B. Traul, formerly of Chapmanville, who has been located recently at Princeton, has moved to Omar.

* * * *

Dr. Otto Hochfeld, who has been located at Bluefield for several years, has moved to Hagerstown, Maryland.

* * * *

Dr. J. A. Spinks, of Berwind, has located for the practice of his profession at Omar.

ALL EXHIBIT SPACE RESERVED

Every inch of space available for technical exhibits at the Windsor Hotel, Wheeling, in connection with the annual meeting of the State Medical Association, May 15-16, 1944, had been reserved by the middle of January. This is a record in itself. Usually space is available until a few days prior to the opening date.

The Windsor and McLure have both been designated as convention hotels. Headquarters will be maintained at the Windsor, where exhibits will be set up and all scientific sessions held. Desirable rooms are still available at both hotels, but it is important that reservations be made without delay. Requests for rooms should be mailed directly to the hotels at Wheeling.

WITH DOCTORS IN THE SERVICE

Captain Raymond B. Nutter, Jr., of Lumberport, who is with the 106th Station Hospital (an original West Virginia unit) somewhere overseas, in writing to wish all the members of the State Medical Association a Happy New Year, says that "there is nothing more welcome to a man overseas than a letter from friends back in the good old U. S. A." He says that the members of Col. Carl Fisher's staff are kept very busy, and that the unit as a whole is doing a good job.

* * * *

Dr. Leonard Eckmann, of South Charleston, who has been attached to the 14th Tank Battalion at Camp Polk, La., is now assigned to the 286th AAA Bn., at Camp Livingstone, in that state. He has recently been promoted to the rank of Captain.

* * * *

Captain C. W. Shafer, of Spencer, is serving as Battalion Surgeon with the Headquarters Company, 1st Battalion, 321st Infantry at Camp San Luis Obispo, Cal.

* * * *

Captain W. P. Warden, of Charles Town, who has been stationed at the Lawson General Hospital, Atlanta, is now assigned to the 396th AAA (AW) Bn., at Seattle, Washington.

* * * *

The V-Mail timing of Major R. A. Updike, of Montgomery, was almost perfect. The Christmas card mailed by him somewhere in India on November 26 was delivered at the headquarters of the State Medical Association two days after Christmas.

* * * *

Dr. P. A. Tuckwiller, of Charleston, has been promoted from the rank of Major to Lieutenant Colonel. He is now serving as Chief of Medical Service at his Station Hospital somewhere overseas.

* * * *

Dr. Richard F. Miller, of Paden City, who has been attached to the 324th Station Hospital at New Orleans, is now stationed at Camp Mackall, North Carolina.

* * * *

In a letter mailed from somewhere in England Dec. 20, 1943, and received January 10, 1944, Major T. B. Gordon, of New Martinsville, says "you can't imagine how very much we appreciate a letter from you all back home. I would like to be with you at your annual meeting at Wheeling, but am afraid that I won't be able to make it. Best wishes for you and all the members of the Association."

* * * *

Lt. Col. Bert Bradford, of Charleston, writes from England that he has seen several doctors from West Virginia. Captain Bernard Moore, of Charleston, is assigned to his outfit. The letter was written on Christmas Day after what Colonel Bradford reports as a "perfectly wonderful turkey dinner."

* * * *

Major Arnold Wilson, of Welch, who is assigned to a station hospital somewhere in England, writes to congratulate the medical profession in West Virginia for supplying in excess of four hundred doctors to the armed forces. He says that Major Claude Smith, of Charleston, is stationed near him, and that Lieutenant Ralph Greenberg, of Wheeling, is in his outfit.

* * * *

Major Norman Friedman, of Longacre, last heard from in New Georgia after the United States troops had taken Munda airfield, V-mails from somewhere in the southwest Pacific as follows: "If I should get to return home on leave by next May (I hope it isn't wishful thinking), I'll be glad to attend the annual meeting at Wheeling. Incidentally, I'd like to extend my regards to Major Arnold Wilson and Captains Warren and Brick through this medium. I don't know their addresses, but I do know that they are not in this theater. (Ed: Major Arnold Wilson's APO address appears elsewhere in this issue of THE JOURNAL. Captain John P. Brick is with the Med. Det., 150th Inf., at New Orleans, but the present address of Captain J. O. Warren is not in the files).

* * * *

Lt. Comdr. L. F. Dobbs (MC), USNR, of Wheeling, is attached to the Naval Auxiliary Air Station at Hollister, Cal.

* * * *

Major James L. Blanton, of Fairmont, is now Chief of Medical Service at the Station Hospital at Camp Carson, Colorado.

Dr. John W. Whitlock, of Amigo, who has been stationed at Camp McCain, Miss., and who is now assigned to the 312th Med. Bn., 87th Inf. Div., at Nashville, has been promoted to the rank of Major. He has completely recovered from a recent operation for appendicitis.

* * * *

Captain H. L. Hegner, of Wellsburg, who has been stationed on the west coast for several months, is now assigned to the 1570th Service Unit, Medical Section, at Camp Breckinridge, Kentucky.

* * * *

Captain James L. Hager, of Charleston, who is Chief of Surgical Service in a station hospital in New Guinea, has written most interestingly concerning the work in his sector. After acknowledging receipt of his copy of the October issue of THE JOURNAL (nearly two months in transit), he says:

"We have a number of hospitals in this area and they are all well equipped and have been highly praised by the Base Surgeons.

"There is very little malaria here any more, and good work is being done in the matter of the control of scrub typhus.

"We have been treating a number of burn cases from explosions of gasoline. These involve usually the upper trunk, face and arms. Our present treatment is cleansing with soft soap and saline solution and applying sterile petrolatum or boric acid ointment, which is further covered with dressings and stockingette. This serves to put the parts to rest and remove any infection. The skin has usually healed beneath the crusts after ten to fourteen days. Of course, this is applicable only to second and third degree burns. First degree burns present no problem.

"This treatment has been highly successful and is in marked contrast to the old treatment of tannic acid sprays and picric acid with bed cradles."

* * * *

Lt. Col. S. S. Hall, of Clarksburg, who has been stationed at Keesler Field, Miss., is now assigned to the 51st General Hospital at Fort Bliss, Texas.

* * * *

Captain J. E. Spargo, former resident at the Wheeling Hospital, is now with the 32nd Base Hospital in Arizona.

* * * *

Captain James T. Asch, of Parkersburg, who is assigned to the Medical Detachment, 12th Infantry, at Fort Jackson, South Carolina, in acknowledging receipt of his 1944 membership card, states that "all of us in the service hope that it won't be too long before we are again practicing medicine in our chosen communities and engaging in constructive work within those communities and states." He has been with the Fourth Division at several locations on the Atlantic seaboard, and says that several West Virginia doctors are assigned to this division, including Lieut. L. M. Strawn, of Morgantown, and Major K. M. McPherson, of Beckley.

* * * *

Dr. C. L. Houck, of Carbon, who is in India, and Captain Joseph Gilman, of Clarksburg, who is with a station hospital somewhere in Italy, have each recently been promoted to the rank of Captain.

* * * *

Lt. Col. Edmond O. Gates, of Welch, commanding officer of a station hospital overseas, writes as follows concerning a meeting of a medical society early in December: "The Iceland Base Command Medical Society met at this hospital last week. After cocktails and a steak dinner, we had an interesting two-hour discussion of the "neuropsychoses," and a case report of "multiple trauma." The paper was of especial interest, as nearly forty per cent of the patients we return to the zone of the interior from this base are of a psychoneurotic nature. Nearly a hundred doctors and dentists, several Icelandic, were present at the meeting."

* * * *

Captain John C. Condry, of Charleston, reports from somewhere in North Ireland that copies of THE JOURNAL are being received regularly. "During the month of January," he writes, "I am going to attend a course in medicine and surgery at Queen's University in Belfast. Besides Americans, there will be many British and Canadian medical officers present. I am anxious to talk with them and compare notes. I have not yet seen any West Virginia doctors in Ireland, but have been corresponding with several who are stationed in England. We are very comfortably located here, and the native Irish people have shown us hospitality 'far beyond the line of duty.' "

* * * *

Capt. Spencer L. Bivens, of Charleston, serving in England, has been promoted to the rank of Major.

* * * *

Captain William L. Claiborne, of Huntington, who has been attached to the 269th Station Hospital at Camp Ellis, Illinois, is now assigned to the 135th General Hospital, at Fort Benning, Georgia.

* * * *

Lt. Comdr. John Lutz, of Charleston, who is serving as ship's surgeon on a tanker somewhere in the Pacific, writes that he has just received the October and November issues of THE JOURNAL.

"There were some addresses of doctors in THE JOURNALS that I had been trying to obtain," he writes. "I always read the 'With Doctors in the Service' section first."

Concerning life on shipboard, he writes: "So far, although we have been over a considerable portion of the South Pacific, we have not seen any real action. That may be changed soon.

"Medicine here is not much different than at home," he says, and then continues:

"Our patients have the usual complaints. We have had mumps, chickenpox and scarlet fever (all in boys just back from leave); acute rheumatic fever, malaria, fractures, dislocated shoulders, lacerated tendons; appendectomy at sea; enlarged toxic thyroid—not uncommon at sea and thought to be due to the fact that we make our own water from salt water; burns; subluxation of cervical spine; and, chronic seasickness.

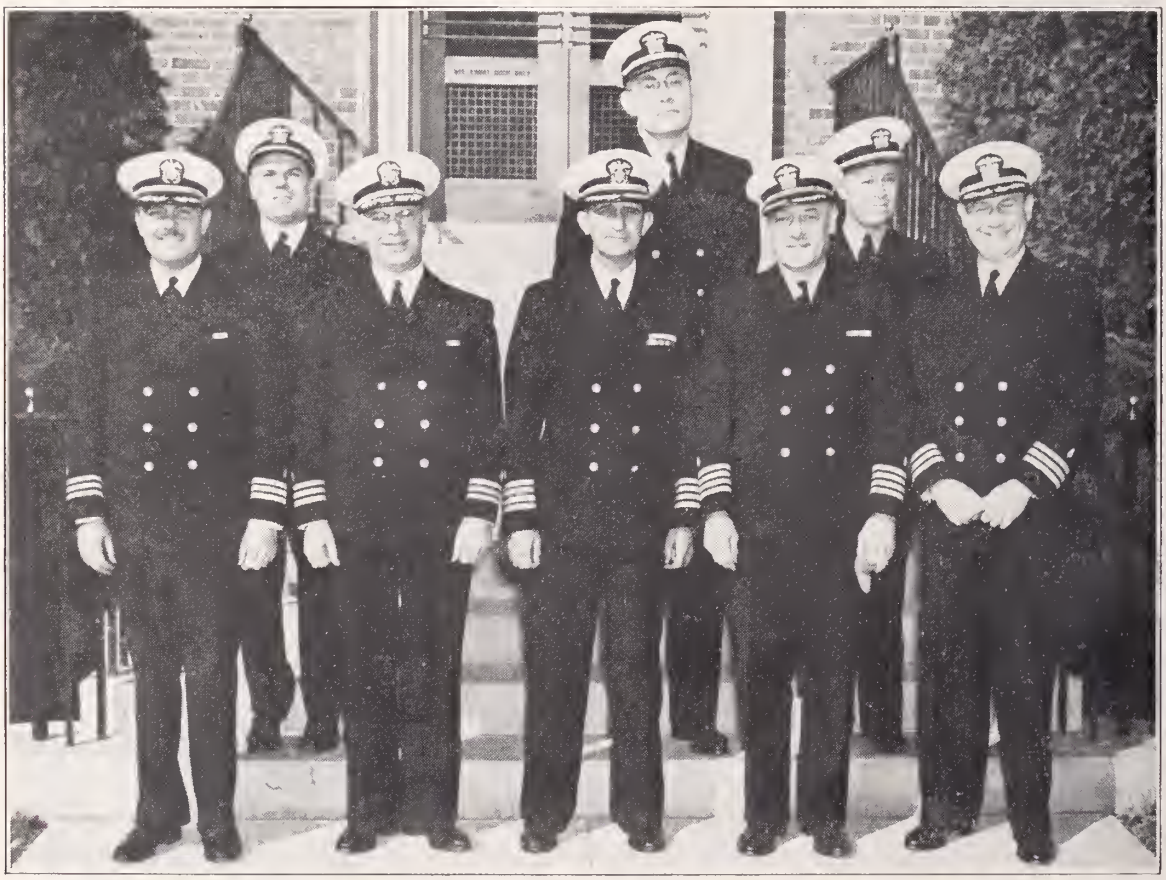
"I have not seen any West Virginia doctors, but have seen a number of men from back home. We have six West Virginians on this ship."

A. C. S. WAR SESSIONS

Twenty-two cities distributed throughout the United States and Canada have been selected by the American College of Surgeons as headquarters for one-day war sessions to be held in March and April, 1944. Advancements in military medicine and developments in civilian medical research and practice under the spur of the war emergency will be presented by authorities representing governmental agencies and by civilian physicians and surgeons.

West Virginia is grouped with Ohio, Kentucky and Indiana, and the meeting for this group of states is scheduled for Wednesday, March 8, at the Netherland Plaza, in Cincinnati.

WEST VIRGINIA PHYSICIANS SERVING IN THE UNITED STATES NAVAL HOSPITAL AT QUANTICO, VIRGINIA



Left to Right: Commander Russel Kessel (MC) USNR, Chief of Surgery, Charleston; Lt. Comdr. W. L. Schafer (MC) USNR, Family Clinic, Wheeling; Commander H. G. Little (MC) USNR, Pathologist, Wheeling, Captain J. M. Brewster (MC) USNR, Executive Officer, Weston; Lt. (jg) Heyes Peterson (MC) USNR, Ward Medical Officer, Wheeling; Captain W. M. Sheppe (MC) USNR, Chief of Medicine, Wheeling; Lt. Comdr. A. L. Osterman (MC) USNR, Psychiatrist, Wheeling; Commander J. K. Stewart (MC) USNR, Dept. E. E. N. & T., Wheeling.

ANNUAL AUDIT

The annual audit of receipts and disbursements of the West Virginia State Medical Association for the calendar year 1943 has been completed by Norman S. Fitzhugh, certified public accountant, and submitted to the treasurer, Dr. T. M. Barber, of Charleston.

Dr. T. M. Barber, Treasurer,
West Virginia State Medical Association,
Charleston, West Virginia.

I have audited the receipts and disbursements of the West Virginia State Medical Ascociation for the calendar year ended December 31, 1943, and am submitting herewith statements covering the various funds for the year under review.

All receipts of record and all disbursements were verified and the cash balances were reconciled with statements of the depository banks. Sufficient tests were made to satisfy me that all receipts had been recorded. Cancelled checks evidencing all disbursements were on hand, except five checks issued in December 1943 in the aggregate amount of $61.22, which checks were outstanding at the close of the year.

I therefore certify that, in my opinion, all receipts in the year under review have been properly accounted for and all receipts and disbursements are correctely stated on the books and in the statements attached hereto. I further certify that the balances in bank at the close of business on December 31, 1943, aggregated $8,205.16.

A statement of cash follows:

Balance December 31, 1942	$ 329.28
Receipts for the period	30,275.15
	30,604.43
Disbursements for the period	22,399.27
Balance December 31, 1943	$ 8,205.16

The cash balance at December 31, 1943 is attributable to the various fund accounts as follows:

General Fund		$ 3,914.27
Medical Journal Fund		14,438.09
		$18,352.36
Deficits—Indigent Fund	$ 2,452.13	
—Medical Defense Fund	1,167.83	
—Convention Fund	1,851.18	
—Nicholson Property Fund	4,676.06	$10,147.20
Total All Funds—Net		$ 8,205.16

The life insurance policy on the life of Dr. Nicholson was inspected. This policy had a cash value of $11,650.00 on December 31, 1943. A premium of $1,256.00 was paid on this policy in 1943.

The Fidelity Investment Association annuity contract was not on hand for inspection having previously been turned over to the receivers. The ultimate recovery on the contract cannot be stated at this time.

A check for the proceeds, amounting to $2,146.50, from the sale in December, 1942 of Postal Savings Bonds owned by the Association was received and deposited in January, 1943.

A comparative statement of assets at December 31, 1942, and December 31, 1943, is as follows:

	Dec. 31, 1942	Dec. 31, 1943	Increase *Decrease
Cash in Bank	$ 329.28	$ 8,205.16	$ 7,875.88
South Ruffner Park Property	8,442.57	8,442.57	—
U.S. Postal Savings Bonds	2,146.50	—	*2,146.50
Cash Surrender Value Life Insurance	11,000.00	11,650.00	650.00

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GASTROSCOPY—Personal Course starting April 3, June 19, and October 16.

OTOLARYNGOLOGY—Two Weeks Intensive Course starting April April 3.

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Annuity Contract — cost	3,544.20	3,544.20	—
	$25,462.55	$31,841.93	$ 6,379.38

NORMAN S. FITZHUGH,
Certified Public Accountant.

Charleston, W. Va.
January 11, 1943.

COMBINED STATEMENT OF RECEIPTS AND DISBURSEMENTS CALENDAR YEAR 1943

BALANCE JANUARY 1, 1943		$ 329.28
RECEIPTS:		
Dues (Net)	$ 9,446.25	
Interest on Savings	1.88	
Special Assessments	9,342.50	
Advertising (Net)	7,205.48	
Sale Postal Savings Bonds	2,146.50	
Emblems Sold	14.00	
Miscellaneous	51.41	
Commercial Exhibits	1,280.00	
Rent—Nicholson Property	780.00	
Refund—Paint Returned	7.13	
Total Receipts		$30,275.15
		$30,604.43
DISBURSEMENTS:		
General Fund	$13,126.79	
Medical Journal (Eliminating Transfers)	5,106.44	
Indigent Fund	1,481.00	
Defense Fund	531.25	
Convention Fund	1,828.10	
Nicholson Property Rent Account	325.69	
Total Disbursements		$22,399.27
BALANCE DECEMBER 31, 1943		$ 8,205.16
Charleston National Bank—Checking Account		$ 8,079.05
Charleston National Bank—Savings Account		126.11
Total (As per Balance Above)		$ 8,205.16

RECEIPTS AND DISBURSEMENTS GENERAL FUND CALENDAR YEAR 1943

BALANCE JANUARY 1, 1943		$*3,896.07
RECEIPTS:		
Dues	$ 9,463.75	
Less: Refunds	17.50	$ 9,446.25
Interest on Savings Accounts		1.88
Transfer from Medical Journal Fund		2,146.50
Special Assessments		9,342.50
Total Receipts		$20,937.13
		$17,041.06
DISBURSEMENTS:		
Salary — Executive Secretary (Less Payroll Taxes)		$ 5,670.30
Office Salaries (Less Payroll Taxes)		2,078.16
Office Supplies and Expense		179.67
Office and Library Rent		900.00
Telephone and Telegraph		530.06
Postage		415.50

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8 pages	9.10	8.10	11.35	9.85	15.10	12.60	22.50	18.50
12 pages	11.75	10.75	14.75	13.25	19.75	17.25	28.65	24.65
16 pages	13.55	12.55	16.55	15.05	20.55	18.05	29.50	25.50
20 pages	16.00	15.00	18.00	16.50	23.00	20.50	35.00	31.00
24 pages	18.00	17.00	21.00	19.50	26.00	23.50	38.00	32.00
32 pages	22.00	21.00	26.00	24.25	31.75	29.25	45.75	41.75

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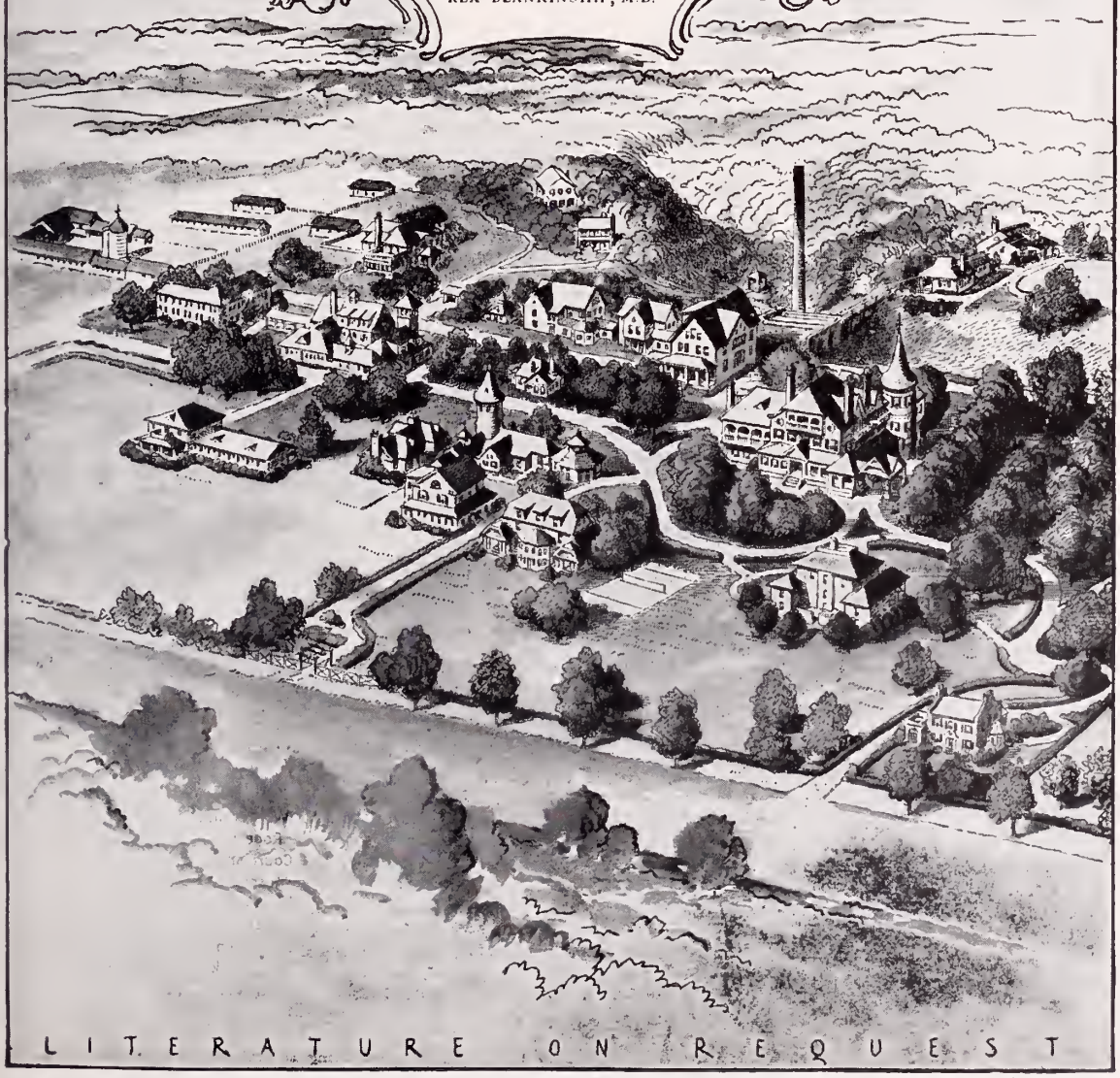

LITERATURE ON REQUEST

Traveling Expense	1,057.32	
Miscellaneous	1,526.44	
Social Security	114.25	
Procurement and Assignment Survey	169.12	
U. S. Victory Tax	167.29	
Dr. Bobbitt Committee Expense	90.98	
U. S. Withholding Tax	227.70	
Total Disbursements		$13,126.79
BALANCE DECEMBER 31, 1943		$ 3,914.27

*Deficit.

RECEIPTS AND DISBURSEMENTS
MEDICAL JOURNAL FUND
CALENDAR YEAR 1943

BALANCE JANUARY 1, 1943			$12,273.64
RECEIPTS:			
Advertising	$ 8,446.32		
Less: Discounts	1,240.84	$ 7,205.48	
U. S. Postal Bonds Sold		2,146.50	
Emblems Sold		14.00	
Miscellaneous		51.41	
Total Receipts			$ 9,417.39
			$21,691.03
DISBURSEMENTS:			
Printing	$ 4,665.78		
Engraving	147.59		
	$ 4,813.37		
Less: Discounts	93.25	$ 4,720.12	
Postage		145.00	
Miscellaneous		241.32	
Transfer to General Fund		2,146.50	
Total Disbursements			7,252.94
BALANCE DECEMBER 31, 1943			$14,438.09

RECEIPTS AND DISBURSEMENTS
INDIGENT FUND
CALENDAR YEAR 1943

BALANCE JANUARY 1, 1943		$ *971.13
RECEIPTS		NONE
DISBURSEMENTS:		
Premiums on Life Insurance — Dr. Nicholson	$ 1,256.00	
Benefits Paid to Mrs. S. A. Daniel	225.00	
Total Disbursements		$ 1,481.00
BALANCE DECEMBER 31, 1943		$*2,452.13

*Deficit.

RECEIPTS AND DISBURSEMENTS
MEDICAL DEFENSE FUND
CALENDAR YEAR 1943

BALANCE JANUARY 1, 1943	$ *636.58
RECEIPTS	NONE
DISBURSEMENTS—Legal Fees	531.25
BALANCE DECEMBER 31, 1943	$*1,167.83

*Deficit.

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Receipts and Disbursements
Convention Fund
Calendar Year 1943

BALANCE JANUARY 1, 1943		$ 1,303.08
RECEIPTS—Commercial Exhibits		1,280.00
		$ 23.08
DISBURSEMENTS:		
Supplies and Labor	$ 427.10	
Traveling Expense	564.46	
Entertainment	278.25	
Reporting	248.01	
Miscellaneous	310.28	
Total Disbursements		$ 1,828.10
BALANCE DECEMBER 31, 1943		$ 1,851.18

Deficit.

Receipts and Disbursements
Nicholson Property Account
Calendar Year 1943

BALANCE JANUARY 1, 1943		$ 5,137.50
RECEIPTS:		
Rents	$ 780.00	
Refund—Paint Returned	7.13	
Total Receipts		$ 787.13
		$ 4,350.37
DISBURSEMENTS:		
Insurance	$ 51.84	
Taxes	90.34	
Repairs	183.51	
Total Disbursements		$ 325.69
BALANCE DECEMBER 31, 1943		$ 4,676.06

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IMPORTANT MEETINGS IN FEBRUARY

The 1944 session of the National Conference on Medical Service will be held February 13 at the Palmer House, in Chicago.

This conference is the only discussion meeting of its kind on the social and economic relationships of medicine, and it provides the one opportunity of the year for representatives of organized medicine from all parts of the country to get together for informal discussion.

In accordance with an established precedent the meeting is held on the day preceding the Annual Congress on Medical Education and Licensure so that as many as possible may arrange to be present at both meetings. Every member of organized medicine is cordially invited to attend and every state association urged to see that it is well represented.

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County Society News

CABELL COUNTY

At the regular monthly meeting of the Cabell County Medical Society, held at the Hotel Prichard, Huntington, Tuesday evening, January 13, 1944, the motion picture (in technicolor), "Contagious Diseases," was shown through the courtesy of Lederle Laboratories, Inc.

GREENBRIER VALLEY

At the regular monthly meeting of the Greenbrier Valley Medical Society held at the Community House in Lewisburg, January 20, 1944, the free distribution of venereal disease drugs and the proposed "rapid treatment" hospital at South Charleston were discussed in detail by Dr. Herbert Duncan, district health officer. The new EMIC program was also discussed by several of the members, who expressed approval of the project. The following officers were elected for 1944: President, J. W. Compton; vice president, K. J. Hamrick; secretary-treasurer, Herbert Duncan; delegate, H. D. Gunning; alternate, A. G. Lanham; board of censors, D. G. Preston.

HERBERT DUNCAN, M. D., *Secretary.*

KANAWHA

The annual banquet and "Ladies Night" of the Kanawha Medical Society was held at the Daniel Boone Hotel, Charleston, Saturday evening, January 8, 1944, at 8 P. M.

Dr. Andrew E. Amick, retiring president, introduced Rev. Joseph C. Hoffman, pastor of Christ Methodist Church, Charleston, as master of ceremonies, who in turn presented Dr. Roy Bird Cook, immediate past president of the American Pharmaceutical Association, as the speaker of the evening. Dr. Cook delivered a most interesting address on the history of medicine in Kanawha County.

The following officers for 1944 were installed: President, Dr. William C. Stewart; vice presi-

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dent, Dr. Randolph L. Anderson; secretary-treasurer, Dr. W. Paul Elkin; and member of the board of censors, Dr. Everett W. Squire.

GEORGE P. HEFFNER, M. D., *Secretary.*

MARION COUNTY

At the regular monthly meeting of the Marion County Medical Society, held at the Fairmont Hotel, December 28, 1943, the following officers were elected for 1944:

President, J. J. Jenkins, Jr.; vice president, F. F. Sowers; secretary, John P. Helmick; treasurer, C. L. Parks; board of censors, D. D. Hamilton; delegate (two-year term), G. V. Morgan; alternate, D. D. Hamilton; alternate (one year) K. Y. Swisher.

JOHN P. HELMICK, M. D., *Secretary.*

MARSHALL

The Marshall County Medical Society held its regular monthly meeting at the Glendale Nurses Home of the Reynolds Memorial Hospital, Tuesday evening, January 18, 1944, at which the following officers were elected for 1944: President, D. B. Ealy; vice president, J. H. Luikhart; secretary-treasurer, J. A. Striebich.

J. A. STRIEBICH, M. D., *Secretary.*

MERCER COUNTY

The annual "Ladies Night" banquet of the Mercer County Medical Society was held at the West Virginian Hotel, Bluefield, December 16, 1943. Captain Leon S. Saler (USPHS), acting assistant director of the bureau of venereal diseases, state health department, and Captain Goodwin, AAC, now stationed at Concord College, Athens, were among the guests present. Following the banquet, the following officers were elected:

President, Frank M. Huff; vice president, H. B. Luttrell; secretary, Frank J. Holroyd; treasurer, Harry G. Steele; member board of censors, Uriah Vermillion; delegate, D. B. Lepper; alternate, Frank M. Huff.

MINGO COUNTY

At the regular monthly meeting of the Mingo County Medical Society, held in the Nurses' Home at the Williamson Memorial Hospital, Jan. 4, the following officers were elected:

President, George W. Easley; vice president, G. B. Irvine; secretary-treasurer, John Carl Lawson; board of censors, W. H. Price, Nathan Poliakoff, and C. E. Peery.

J. C. LAWSON, M. D., *Secretary.*

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Woman's Auxiliary

KANAWHA

The regular monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society was held at the Woman's Club, Charleston, January 11, 1944.

Mrs. A. C. Chandler delivered an interesting review of Dr. George Seagrave's book, "Burma Surgeon." Mrs. John W. Hash gave a report and review of *Hygeia* for 1943.

The meeting was attended by 38 members and two guests.

MRS. V. L. PETERSON, *Chairman*,
Press and Publicity.

RALEIGH

The regular monthly meeting of the Woman's Auxiliary to the Raleigh County Medical Society was held at the Coca-Cola Building, Beckley, January 17, 1944, at 2 P. M. An interesting address was delivered by the Hygeia chairman, who reported that several new subscriptions had been obtained. The meeting was attended by 14 members and two guests.

MRS. J. M. CORAM, *Corresponding Secretary*.

GREENBRIER VALLEY

The Wagner-Murray bill (S. 1161) was discussed at the regular monthly meeting of the Woman's Auxiliary to the Greenbrier Valley Medical Society, held in the Community House at Lewisburg, January 20, 1944. A resolution expressing opposition to the bill was unanimously adopted and the secretary was directed to report the action of the Auxiliary to members of the West Virginia delegation in Congress.

Mrs. H. D. Gunning spoke interestingly concerning the meeting of the state auxiliary.

MRS. HERBERT DUNCAN, *Secretary*.

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TUBERCULOSIS ABSTRACTS

(Continued from page 53)

The dry scabs apparently bear no relation to communicability.

Meningococcus Meningitis.—Probably communicable throughout the course of the disease and until the meningococci have disappeared from the secretions of the nose and throat. Release from isolation is usually safe when 14 days have elapsed since the onset and the fever has subsided.

Poliomyelitis. — Apparently communicable the last one or two days of the incubation period, and for the first seven to ten days of the disease (virus may be found in the stools even much later in the disease). Isolation is necessary only during the first 14 days following onset.

Smallpox.—This disease is apparently the most communicable of all diseases. It is communicable from the inception of the first signs or symptoms until the complete disappearance of all crusts and scabs. There is some evidence that the disease is communicable in the last one or two days of the incubation period. Isolation in screened quarters, free from vermin, is necessary until recovery is complete and all crusts and scabs have disappeared.

Diphtheria. — Communicable from 24 hours before the onset of symptoms until the diphtheria bacilli have disappeared from the nose, throat or other site of infection. Isolation should be continued until symptoms and discharges have ceased and two successive nose and throat cultures, taken no less than 24 hours apart, are negative.

BuMed News Letter, Bureau of Medicine and Surgery, U. S. Navy, Captain W. W. Hall, Editor. (Journal-Lancet, October, 1943).

Tuberculosis, too, is communicable. Tuberculosis, too, can be found preclinically, using the tuberculin test and the chest x-ray. Tuberculosis contacts, too, must be looked for, examined and protected from further known exposure. Tuberculosis, too, responds to prompt, adequate treatment. By all means keep tuberculosis on your list!

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Vol. XXXX March, 1944 No. 3

ACUTE RESPIRATORY INFECTIONS, INCLUDING VIRUS PNEUMONIA*

By HENRY FIELD, Jr., M. D.
Ann Arbor, Michigan

Although it is intended to give greater attention to the subject of current interest, pneumonias thought to be of virus etiology, reference should be made to the large volume of work done in recent years, much of it published in journals of small circulation, concerning the much more frequent common cold and influenza.

Knowledge of the etiology of the latter two diseases is essential for a logical basis for prophylaxis and treatment. Their etiology has been studied in two different ways. Several intensive studies have been made of the bacterial flora of the nasopharynx—periodically during health and daily during colds. These have shown no change in the incidence of cultivatable bacteria at the onset of a cold, and usually no change in the bacterial flora throughout its course. In some instances there has been, in the later days of a cold, an increase in the numbers of some organism, indicating its activity as a secondary invader.

THE AUTHOR

Dr. Henry Field, Jr., graduate Harvard Medical School; Professor Internal Medicine, University of Michigan.

Another approach to the etiology of colds and influenza has been the inoculation of volunteers with bacteria-free filtrates of secretions from the nose and throat of patients or with tissue cultures from such filtrates. The disease has been reproduced in a large proportion of subjects inoculated with such bacteria-free filtrates or cultures. The viruses of the common cold and of influenza have different cultural characteristics. The influenza virus may be studied by animal inoculation but that is not, as yet, true of the cold virus.

These facts have an obvious bearing upon the prophylaxis and treatment of these diseases and require due consideration. If the common cold and influenza are due to viruses, the only rationale for bacterial cold vaccines would be the hope of preventing the secondary infections which sometimes occur.

*Presented before the 76th annual meeting of the West Virginia State Medical Association, at Charleston, May 17, 1943.

In order to accomplish this, it would be necessary to include in such a vaccine the 32 Cooper strains of pneumococci, possibly the 72 strains of pneumococci differentiated by finer serological methods, and the numerous strains of other cocci which have not yet been completely identified.

Reports concerning the results of bacterial cold vaccines have been rather conflicting but most studies of adequate size and control have not shown significant benefit from such vaccines. In some studies, as good improvement over the recollection of previous years has been obtained with placebos as with vaccines.

Some encouragement to prophylaxis against the more commonly serious causes of pneumonia has been given by the results of vaccination against types I and II pneumococci in C.C.C. camps as well as by other similar studies. The frequency with which second attacks of pneumonia are due to the same type of pneumococcus as the first attack indicates a short duration of immunity and the necessity for frequent repetitions of vaccination. Also, if only partial protection is obtained against two types of pneumococci, it does not seem probable that a very significant immunization will be produced by a more polyvalent vaccine, by present methods.

It has been a common practice to use sulfonamides in the treatment of colds. Sulfonamides have not been shown to be of benefit in the treatment of any virus infections except lymphogranuloma venereum and trachoma. They have not influenced significantly experimental animal infections with the influenza virus. In one study during the influenza epidemic of 1940-41, the composite temperature and pulse charts of 42 patients treated with sulfapyridine were practically superimposable upon the corresponding charts of 26 cases who did not receive sulfonamide therapy. In a series of 670 cases of simple respiratory tract infections in an army station hospital, the 317 cases who received full doses of sulfadiazine showed no significant difference from those who received only symptomatic treatment.

It would seem that the only rationale for the use of sulfonamides in the treatment of uncomplicated colds is the prevention of complications. This might be an important indication during an epidemic, like the influenza of 1918, when complications were very frequent and very serious. There are also occasional cases where the prevention of complications is of sufficient importance to warrant prophylactic doses of sulfonamides. When this is to be done, it is probable that something approaching full therapeutic doses should be used.

Otherwise, it seems better to be on the alert for complications and to use sulfo-

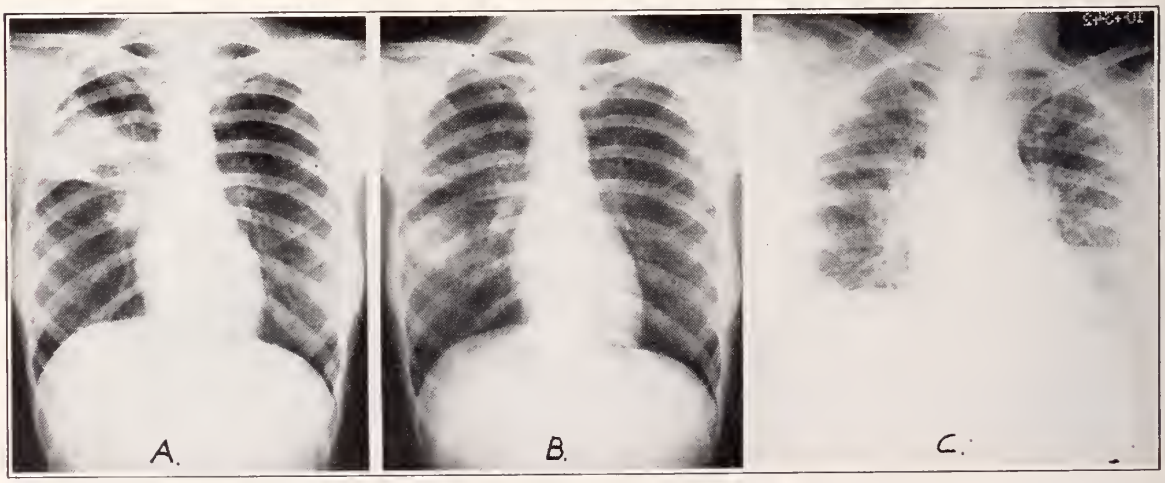

Fig. 1. (A and B). Case 1: Typical mild course. (a) X-ray appearance after three days of gradual development of symptoms. Temperature 102°. No abnormal physical findings. (b) New consolidation in the lower lobe with rise in temperature to 100.5° after having been normal for two days. (c) Case 2: Bilateral granular infiltration which required consideration of miliary tuberculosis.

namides only at the earliest time when there is sufficient evidence of their occurrence.

The routine use of sulfonamides in simple respiratory infections may cause much unnecessary discomfort and may be more immediately dangerous than the disease. The use, at least of some, sulfonamides may be followed by a sensitization so that these drugs give bad reactions when they are used a second time when there may be a real need for them. Another objection to the unnecessary use of sulfonamides is the possibility of the development and spread of strains of organisms which are resistant to sulfonamide therapy. Such resistant strains are easily produced experimentally.

The possibility of benefit from the local use of sulfonamides in simple respiratory infections is another problem concerning which further information is desired.

There has been a large number of reports in recent years of series of pneumonia which have been recognized as being of a different type, clinically from the usual pneumonias. For several years the suspicion has been growing that these unusual pneumonias had a special etiology—perhaps a filterable virus. The suspicion of virus etiology was based upon the failure to demonstrate an abnormal bacterial flora in the sputum; the finding, in the few cases which came to autopsy, of a mononuclear rather than a polymorphonuclear exudate, sometimes with inclusion bodies, which is the type of exudate found in diseases of proven virus etiology, and the failure to respond to sulfonamides.

In the last two years that suspicion of virus etiology has been confirmed, at least for some cases. In a number of instances there has been isolated from such atypical pneumonias a virus which is serologically indistinguishable from that of psittacosis, although it is much more benign in experimental inoculations. This psittacosis-like virus is not the only cause of atypical pneumonias. The development, during convalescence, of complement-fixing antibodies for this virus was demonstrated in only about one quarter of such cases in one study. The virus of benign lymphocytic choriomeningitis has been isolated from two cases of pneumonia. Viruses which have not been identified biologically have been isolated from other cases.

It is probable that there has been a real increase in the incidence of "virus pneumonias" in recent years. There has been a decrease in the incidence of reported pneumococcus pneumonias in the last ten years despite campaigns by various health departments which should have encouraged the recognition of them. However, it is probable that a considerable part of the increase in "virus pneumonias" has been more apparent than real. When chest x-rays have been taken

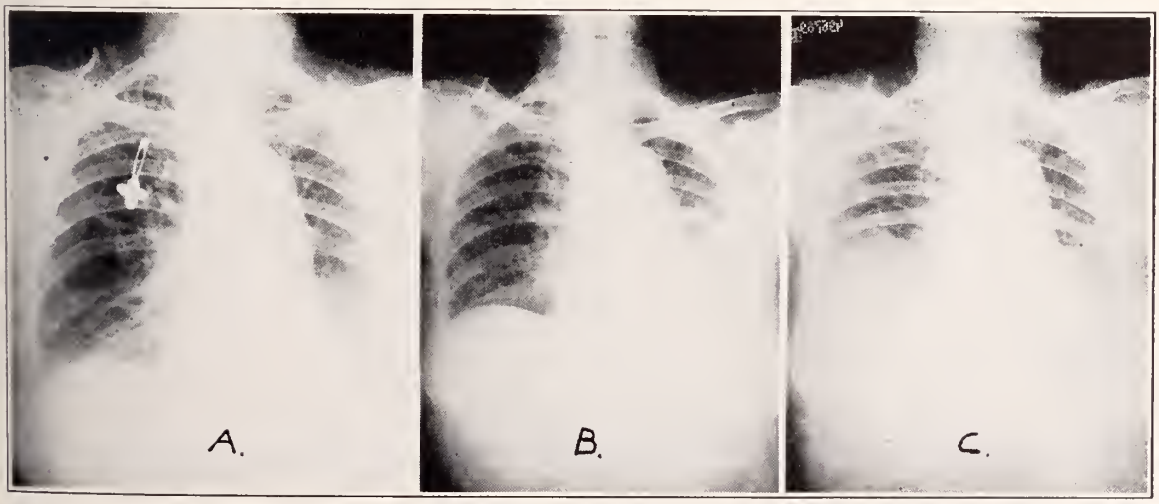

Fig. 2. Case 3: Unusually prolonged course with afebrile periods of three to fourteen days. Involvement of both bases, then left base, then right base. Three months before final resolution. (a) at onset, (b) after three weeks, (c) after 2 months.

freely in patients with acute respiratory infections of any severity, as has been done in our student health service and among the staff of our hospital, it has been remarkable how frequently unexpected consolidation has been demonstrated. Many such patients had no abnormal physical findings in the chest. Without the x-rays they would have been considered as having only bad colds. Others have had râles without signs of consolidation and might have been diagnosed acute bronchitis. For many years I have taught that the finding of râles in the chest of a patient with acute respiratory infection should be considered probable evidence of pneumonia and that the diagnosis of acute bronchitis was untenable without x-ray evidence of the absence of pneumonia. I saw an unprecedented number of patients with acute respiratory infections, râles and negative chest x-rays this past winter.

Despite the probable multiplicity of etiological viruses there is a fairly characteristic basic clinical picture of these atypical pneumonias. In many instances it is characteristic enough to justify a probable diagnosis on clinical grounds. The importance of the clinical diagnosis is the ability to give a very probably favorable prognosis with the warning that a sulfonamide miracle is not to be expected.

RESERVATIONS NEEDED IN CLINICAL DIAGNOSIS

A clinical diagnosis of virus pneumonia, however, should be made with reservations. Failure to respond promptly to sulfonamide therapy is not, in itself, an aedquate basis for such a diagnosis. It is a reason for careful scrutiny of the evidence and search for other less common causes of pneumonia. Sulfonamide resistant strains of pneumococci are not rare. Penicillin has been effective against such strains and their recognition will be particularly important when penicillin is more available. Streptococcus and staphylococcus pneumonias have frequently not responded strikingly to sulfonamide therapy but continuation of sulfonamide therapy in such cases seems indicated, pending further observations on the efficacy of penicillin in their treatment. Failure to respond to sulfonamides has been the stimulus to the search for and identification of, by dark field examination or silver stain, large numbers of the fusospirochetal organisms in the sputum of a number of my patients.

The onset of "virus pneumonia" has been described as influenza-like. This description applies more to the type of symptoms than to the course of their development. There is usually cough, malaise and aching as in influenza but these symptoms do not occur with the explosive abruptness characteristic of influenza. Commonly the cough appears first. The fever and constitutional symptoms develop gradually over a period of from one to four days. Coryza occurs early in the course of some patients but, as in influenza, is not usually a prominent symptom.

COUGH

The cough is rather characteristic. It is an irritative cough due to a tracheitis and bronchitis which frequently cause a substernal soreness and make the cough painful. It occurs in paroxysms which may be very annoying and difficult to control. At first it is nonproductive. Later there may be more or less sputum. This is usually more mucoid than purulent. It is rarely bloody and the occurrence in it of more than an occasional streak of blood is presumptive evidence against a virus etiology.

Pleuritic pain or effusion rarely, if ever, occur and, likewise, are presumptive evidence against a virus etiology.

Another dissimilarity from influenza is that headache is usually a more distressing symptom, as the disease develops, than is a more generalized aching.

The condition appears to be a systemic as well as a localized disease. This is indicated by the occurrence in some cases of a skin rash, an enlarged spleen or a delirium which is not explainable by anoxemia or by the height of the fever.

Variations in the clinical pictures of the supposed virus pneumonias are largely varia-

tions in the severity and the duration of the disease. The majority are rather benign infections. In them the temperature is commonly normal in from four to six days after its maximum and the patient is never very sick. Something less than half of the patients are moderately to severely ill. Deaths have been few. The disease may be considerably prolonged, usually with exacerbations of fever which correspond with the development of fresh areas of consolidation. This tendency to migration of involvement is an outstanding characteristic of virus pneumonias. Because of this possibility, it is well not to be too optimistic with the first remission and thereby cause disappointment.

As in our experience, noted above, with bronchopneumonia among our staff members, physical findings are usually meager. Corresponding with the slow development of the disease and with a commonly central distribution, extending outward from the hilum, signs are late in appearing. There may be no abnormal physical findings in the chest after a few days of cough and gradually rising temperature when fairly extensive consolidation is apparent by x-ray examination. Râles are usually the first sign to appear. Corresponding with the usually mild density of the infiltration seen in the x-ray films, there are seldom signs of complete consolidation.

As has been said, the sputum does not contain any predominance of any pathological organism.

In the initial stages, the white count is normal or slightly depresssed and the differential count is normal. A considerable proportion of patients will develop a moderate leucopenia after a few days. It has been reported that some patients may develop a leucocytosis late in the course. In my experience that has usually been explainable by some complication.

The x-rays are not diagnostic of the etiology of a pneumonia, but they can be rather suggestive of a virus etiology. The most common picture is a soft, diffuse infiltration which begins at the hilum and gradually extends outward in the shape of a fan. It is rarely as dense as a lobar pneumonia. The shadow is commonly pretty homogeneous but it may be more or less mottled or "fluffy" in appearance. The mottling can be fine enough to bring the question of miliary tuberculosis into the differential diagnosis.

SUMMARY

The common cold and influenza have been shown to be due to filterable viruses. They are occasionally complicated by secondary bacterial infection. The only apparent rationale for the use of bacterial cold vaccines or the treatment of these diseases with sulfonamides is the prevention of secondary infection. It is usually better to withhold sulfonamide therapy in the common cold and influenza until there is sufficient evidence of a complicating infection which may be benefited by it.

The apparent increased incidence of virus pneumonias and their clinical characteristics has been discussed.

DISCUSSION

Chairman Wade: The Scientific Committee has decided, and I think very wisely, upon no formal discussions of papers, but to throw open the meeting for ten or fifteen minutes for questions directed toward the speaker, so I will hand the ball back to Dr. Field and you may fire your questions at him.

Dr. Field: This is the first question which has been sent up: What is the rate of recurrence of these infections, especially of the virus pneumonias?

I don't believe that we have any information about recurrence of virus pneumonias after convalescence has been well established. I spoke of relapses being particularly characteristic of virus pneumonias. If, with "these infections" you include influenza, we do have a little information on that. There are different types of influenza virus, and when we have a recurrence of influenza we can't call it a recurrence of the same infection until we have proved that it is due to the same virus. There has been laboratory proof of a recurrence of influenza A virus infection within two years after the initial infection.

Chairman Wade: Please discuss further the incubation period of viruses. Is it two to three weeks?

Dr. Field: Most people who have reported upon the incubation period of the virus pneumonias have been agreed that it is from ten days to three weeks. One observer has thought that there were two types of virus pneumonias, one with a short incubation period of two or three days, and the other with a longer incubation period. I might say that a long incubation period is characteristic of almost all virus infections. Influenza virus and cold virus are two exceptions to that; they have short incubation periods.

Chairman Wade: What treatment best hastens convalescence?

Dr. Field: Just good treatment in general. As I said, the sulfa drugs do not influence the course of the disease.

Chairman Wade: Here are two which might well come together, perhaps. Are bronchoscopic procedures of benefit in virus pneumonia? Has there been any atelectasis following or associated with a virus pneumonia?

Dr. Field: I wish that it were easier to define the indications for bronchoscopic aspiration in pneumonia. More or less atelectasis occurs in most pneumonias, particularly those which develop postoperatively. There has not been much follow-up of the work of Coryllos with bronchial aspiration in lobar pneumonia. Major atelectasis does not seem to have been common in virus pneumonias.

The site of the obstruction will be an important consideration in estimating the probable benefit from bronchoscopic aspiration. There have been cases of complete lobar atelectasis, found at autopsy to be due to exudate in the smaller bronchi. Exudate, so situated, would not probably be removed by aspiration. I have lantern slides of such a case of complete lower lobe atelectasis in which the larger bronchi were demonstrated to be patent by filling with lipiodol. Bronchoscopic aspiration did not affect the atelectasis in that case. There was subsequently a gradual and finally complete aeration of the atelectatic lobe.

In lobar atelectasis, physical signs apparently help in locating the site of obstruction. In the case just mentioned, the patency of the larger bronchi and some ventilation of the involved lobe were presumably the conditions which permitted loud bronchial breathing over the atelectatic lobe. In another case recently seen in consultation to consider bronchoscopic aspiration for lobar atelectasis which developed in a case of probable virus pneumonia, breath sounds were only moderately diminished over the atelectatic lobe. That patient had been kept lying on the affected side. Perhaps that was an important factor in the development of atelectasis. It was observed, during examination, that movements stimulated cough and raising of sputum. Because of this and the evidence from the breath sounds that a main stem bronchus was not completely obstructed, aspiration was decided against. Changes of position and cough were encouraged and in a few days the atelectatic lobe gradually expanded.

In pneumonia with a patchy consolidation which is not due to obstruction of a main stem bronchus, it is more difficult to estimate the indications for bronchoscopic aspiration.

Chairman Wade: Does x-ray therapy influence the course of virus pneumonia?

Dr. Field: I have no information on that subject.

Chairman Wade: What are the most common complications of a virus pneumonia?

Dr. Field: I think virus penumonia has been remarkably free of complications. They rarely have pleurisy. Unless they are secondarily infected, I think they don't have empyema.

The next question: A few years ago there was an investigation of Australian Q. fever as a cause of virus pneumonia. Have there been any subsequent developments?

Yes, there have been. There was an outbreak of six or eight cases, I think, in the National Institute of Health in Washington that was due to Q. fever. They were thought to have been acquired through experimental animals. There have been recognized a very few cases in Montana and adjacent Idaho of a pneumonitis which was due to Rickettsia—perhaps an American Q. fever.

This question is: Do you find any myocardial involvement with at times acute dilatation and decompensation associated with influenzal pneumonia?

Yes, that can happen. It can happen in any pneumonia with a severe enough toxicity. I don't know

of any specific myocarditis other than the general toxic effect.

Chairman Wade: What is the end result? Do some of these cases go on to fibrosis?

Dr. Field: Of virus pneumonia, I take it that question means. I don't know that they do. I think the complications of virus pneumonias are remarkably few.

Chairman Wade: Is sulfaguanidine of any value in the treatment of lung infections?

Dr. Field: It could be. Sulfaguanidine was introduced for the treatment of intestinal infections because it was not supposed to be absorbed very much from the intestinal tract. However, quite significant concentrations of the drug—between six and ten milligrams per 100 cc.—have been found in patients receiving therapeutic doses. I do not think that sulfaguanidine would be the treatment of choice in any lung infection.

Chairman Wade: How much sulfa drugs should be given? How do you tell when to stop?

Dr. Field: When you use the sulfa drugs you want to use enough to get an effect if you can. The rather standard dosage of sulfa drugs has been a gram every four hours for the average size person throughout the twenty-four hours. With sulfathiazole, it has frequently been necessary to use a gram and a half every four hours in order to get the blood content up to the desired level. I think there is included in that question how long it should be continued.

Chairman Wade: When to stop.

Dr. Field: I think if your patient is not well on his way to recovery in forty-eight hours, the sulfa drug is not influencing the infection very much. I might carry it on for a day or two longer, but certainly not longer than four days if it is not apparently helping the patient.

COMPLICATIONS OF EARLY PREGNANCY*

By A. P. HUDGINS, M. D.
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It is wise in approaching a subject of this nature to divide the symptoms into two large groups. First, those which are serious or may become serious, (that is, threatening the life of the mother or the pregnancy) and second, those symptoms which are annoying but have little possibility of being fatal.

I. Serious complications:
   a. Bleeding or cramping.
   b. Pernicious, uncontrolled vomiting.
   c. Heart disease–marked or advanced.
   d. Hypertension.
   e. Nephritis (the toxemias still account for about one-half of the deaths during pregnancy).
   f. Pyelitis (if uncontrolled with prolonged temperature).
   g. Ovarian cyst (especially if large or if it gives any signs of complications such as pain or tortion).
   h. Ectopic pregnancy.
   i. Syphilis.

II. Annoying complications:
   a. Nausea and vomiting.
   b. Pyelitis.
   c. Backache.
   d. Legache.
   e. Emotional disturbances.
   f. Anemia.

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As physicians it is our job to make pregnancy as comfortable and as tolerable as possible. There is, however, a happy medium between giving careful and sympathetic consideration to the various symptoms which are presented by the pregnant woman, and the extreme of indulging a neurotic. Many women have stated that they dread the pregnancy or "those awful nine months" more than the actual labor itself. They do this perhaps realizing that the average physician is more diligent in relieving actual pain at delivery than he is in caring for the annoying symptoms which frequently accompany pregnancy. These same women realize at times that the symptoms are "foolish and not serious," yet they continue to say that the nuisance value spread over a period of nine months is extremely wearing.

A complete history and examination should be the first step in caring for the pregnant woman. By this method an old tuberculosis, heart lesion or hypertension may be found. Pregnancy, technically, complicates these previously existing diseases. Consultations are of the utmost importance.

GASTRO-INTESTINAL SYSTEM

Many symptoms referable to this system may be due basically to the same underlying functional disturbances whether the complaint be actual nausea, with or without vomiting, bad taste, anorexia, food aversions, heartburn, gastric distress or gas.

Functional digestive disturbances are poorly borne by the woman who is pregnant. There may be a subclinical derangement of the gastro-intestinal tract which does not manifest itself by any obvious symptoms until the woman has the increased tension of a gestation, and as soon as pregnancy takes place the symptoms occur. One point which has brought the writer to this conclusion is the use of alkalies as the time-honored, temporary palliative treatment for the various symptoms of gas, distress and even slight nausea. A large number of these patients will be more definitely improved by the use of dilute hydrochloric acid. In such instances, not only are the gastric symptoms relieved by the acid but also other symptoms are helped as will be brought out later.

Technically and scientifically it is much more satisfactory to have a gastric analysis made to determine accurately the status of the digestive secretions. However, this is not always practicable or desirable, partly because of the increase in expense, and partly because of the extreme aversion to swallowing a stomach tube particularly at this time. Frequently the clinical test can be made by administering small doses of dilute hydrochloric acid to see how the drug is tolerated. If it does not induce increased gastric distress and does give some element of relief, its continued use is justified.

ETIOLOGY OF NAUSEA

The cause or etiology of the proverbial nausea and vomiting is usually classified under three chief headings: (1) reflex stimulation, (2) neurosis and (3) essential toxemia.

The term and classification "reflex stimulation" has been discarded by many workers thus placing the entire group under the latter two classifications.

Many investigators, chief spokesman perhaps being Plass, claim that neurosis is the main and perhaps only cause of hyperemesis gravidarum. The reasons presented for this theory are: 1. Persistent nausea and vomiting are rarely found in the woman who must hide her pregnancy (the unmarried mother). 2. Nausea and vomiting are rather rare in certain races (the Negro). 3. The mother who does not want the pregnancy is very demonstrative in her symptoms and very resistant to treatment. 4. When the woman is put in a room by herself where her demonstrative symptoms will not strike a responsive chord they more quickly subside than they do, for example, in a ward or at home.

With these thoughts in mind treatment has been based around the usual symptomatic approach along with seclusion and psychotherapy.

The second and more widely accepted

theory of the cause of the nausea and vomiting during pregnancy, is that it is an essential toxemia which acts as a trigger in starting a poorly balanced gastro-intestinal tract into a series of symptoms.

It has been said that if this complaint begins after the third month it is not the typical hyperemesis gravidarum. The symptoms may appear when the stomach is empty or when too much food is taken.

While it is always wise to make every effort to relieve the patient of any gastro-intestinal tract symptoms which may be presented, it is urgent to do so when the examination reveals loss of weight, dehydration, salivation, rapid pulse, low blood pressure, exhaustion, fever or neurological changes.

During the early part of pregnancy it is important to know what is normal in weight gain. For instance, in the first three months of pregnancy there is normally no weight gain. From the third to the sixth month the gain is at the rate of about one-half pound per week. The fetus is supposed to weigh about one pound at the sixth month of gestation. From the sixth to the ninth month the proper weight gain is about one pound a week.

It is true that the pregnant woman who is underweight may be allowed to gain a few more pounds of body weight thus bringing her up to the average or normal weight.

Treatment of gastro-intestinal symptoms brings to mind a long list of methods and drugs which have been tried with varying degrees of success.

TREATMENT OF DIGESTIVE SYMPTOMS

1. Avoid preparation of food.
2. Painting cervix with iodine.
3. Replacing retroverted uterus.
4. Frequent food intake.
5. Dry food.
6. Psychotherapy (reassurance, etc.)
7. Sedatives.
8. Alkalies.
9. Dilute hydrochloric acid.
10. Proctoclysis every six hours (Karo in four ounces of water).
11. Soda water to cause vomiting.
12. Vitamin B (orally or intramuscularly).
13. Stilbestrol.
14. Bed rest.
15. Hospitalization.
16. Isolation.
17. No food for twenty-four hours.
18. Duodenal tube feeding.
19. Intravenous glucose.

It will be noted from this list that there is a distinct division in the treatment. Hospitalization is required in most instances for the last four methods. As a matter of fact, some observers believe that in extreme cases hospitalization, in that it removes the patient from her home surroundings, is very important and a definite element in the results obtained.

It is also to be noted that some of these methods are not practicable in many instances, for example, avoiding preparation of food. The average mother would be seriously disturbed in her home routine if this were absolutely carried out. Therefore, its usefulness is limited except where urgently required.

Frequent Meals: The woman may prepare some dry food (a piece of toast or a few crackers) to be put by her bed and eaten as soon as she awakes in the morning. Good results are obtained by putting something into the stomach before the odor of other foods has had time to disturb the reflexes associated with digestion. Also, a small amount of food taken between meals, for example, a sandwich, a piece of fruit or a glass of milk is helpful.

Sedation is a time honored method and may be approached from several angles. Small doses of sedatives may be given at 9 a. m., 3 p. m., and 9 p. m., with satisfactory results, or a larger dose may be given at bedtime which may have a prolonged effect during the next day. Ten or fifteen grains of chloral hydrate given by proctoclysis may be included with the Karo mentioned later in this paper.

Dilute Hydrochloric Acid: It is, perhaps, unscientific to speak of "trying" methods but

it does seem that more and more physicians in the beginning "try" the acids rather than the alkalies in the treatment of various disturbances including gastro-intestinal derangements. For example, recently at a state medical meeting an outstanding otolaryngologist recommended the use of dilute hydrochloric acid instead of alkalies in the treatment of coryza. Therefore, if the more scientific and exacting method of the gastric analysis cannot be conveniently carried out the therapeutic test of dilute hydrochloric acid certainly will not do any harm.

PROCTOCLYSIS

Proctoclysis, using three tablespoonfuls of ordinary Karo syrup in about four ounces of lukewarm water (which is a small cupful), is injected into the rectum and should be retained. A few simple but very definite instructions should be given the patient: She should first take a small soda or plain enema. Then, for the proctoclysis, a small rubber bulb syringe should be used; repeat this procedure every six hours (9 a. m., 3 p. m., 9 p. m.), avoiding injection of air; explain to the patient the possible enema effect of the solution.

Vitamin B, orally or intramuscularly, is one of the newer methods of treatment. Orally it may be more effective if given with dilute hydrochloric acid.

Stilbestrol: This is one of the newer methods and at times the most dramatic, in treating nausea of pregnancy. How can stilbestrol stop nausea when it often causes nausea? Because stilbestrol, even in doses of 5 mg., rarely if ever, causes nausea if the patient is pregnant. For this reason it has been frequently used as a method of diagnosis of early pregnancy. Five milligrams of stilbestrol is given every night increasing the dose 5 mg. each night until nausea is relieved. The writer has given as much as mg. 25 to 50 and has obtained satisfactory results, not only in nausea of pregnancy but also in overcoming the associated weakness and depression. Several patients have reported that they experience marked improvement, even a feeling of exhilaration, following the taking of stilbestrol. The continued use of stilbestrol has not been found to be as satisfactory at times as the vitamin B with dilute hydrochloric acid. The remaining well established methods are frequently discussed and will need no special comment at this time.

The use of vitamin B during pregnancy has, however, aroused so much interest and comment that it may be wise to mention it here in more detail. It has been found that a pregnant woman requires more vitamin B than does a woman who is not pregnant. With this in mind it may be expected that the administration of vitamin B will produce more marked results or the lack of vitamin B may produce more rapid and more outstanding symptoms. Brewers' yeast has been found to be a very acceptable and economical method of administering vitamin B. It is found that this vitamin is better absorbed if it is given with meals, that is, on a full stomach, perhaps because hydrochloric acid is necessary for its adequate assimilation.

VITAMIN B AND HYDROCHLORIC ACID

Some recent investigation (Hart) has proven that there is an inter-relationship between the assimilation and administration of vitamin B and hydrochloric acid. If an adequate amount of hydrochloric acid is in the stomach the vitamin B is better utilized by the body. Also, it has been found that increased doses of vitamin B tend to increase the effectiveness of the digestive juices which are in the stomach. With this in mind it has been found advisable to consider the administration of hydrochloric acid when there is evidence of a deficiency. While giving dilute hydrochloric acid to a comparatively large number of patients recently, there was a definite wave of objection concerning the taste, some women saying that they would rather not eat than to have to take it. They stated also that the taste of it increased the stomach discomfort. An attempt was then made to improve the administration of this drug. It was found that No. 2 plain gelatin capsules hold about nine drops of dilute

hydrochloric acid. The patient was instructed to have capsules, dilute hydrochloric acid, a dropper and the liquid with which the drug is to be taken, all together. Then, one at a time, the large section of the capsule was to be filled with the hydrochloric acid, closed and taken immediately with water or milk, thus avoiding possible injury to the teeth and also avoiding the taste of the drug. It has been found that more satisfactory results are obtained if one of the capsules is taken before eating and the remainder of the dose during or at the end of the meal. The therapeutic effects will more than justify the added trouble.

Constipation: This is a common complaint with women and is more marked during pregnancy, perhaps because of the pressure incident to the enlargement of the uterus, the altered diet during pregnancy (food aversion, etc.) and also to the actual disturbances of the gastro-intestinal tract such as the frequent need for increased hydrochloric acid in the stomach. Also, there is definitely less physical activity during pregnancy.

TREATMENT

The treatment for constipation is best accomplished by the use of a definite outline:

1. Diet—green vegetables and fruit.
2. Water—three glasses of hot water before meals, one glass every hour.
3. Time habit—to toilet after meals three times daily.
4. Exercise—walk two to three miles a day.
5. Inject two to three ounces of mineral oil into rectum to be retained until morning.
6. Vitamin B.

The patient should be made to understand that this diet, increased intake of fluids, regular time habit to the toilet and an increased amount of exercise should be considered a part of her daily routine and not as an inconvenience.

Skeletal System: Troublesome symptoms connected with the skeletal system are somewhat related when traced to their cause and treatment but they are frequently presented to the doctor as backache, sciatic pain, pressure pains, aching in the calf of the leg and a group of symptoms known as polyneuritis.

Backache: Let's consider some common sense facts concerning backache. Let's try to find some of the causes of backache when not associated with pregnancy. We know that one of the common causes of backache, in connection with the female organs, is some form of pelvic pressure. When this pressure is caused by pregnancy we must see what can be done to relieve it by palliative methods. Other types of backache are those which are due to defects of posture and perhaps those due to the effect of ill-chosen shoes. Another cause of backache which is outstanding in the obstetrical field is that which is due to a vitamin deficiency.

ADEQUATE REST

A sensible attitude in the treatment of backache certainly would include adequate rest, perhaps with elevation of the feet, heat, massage and attention to posture with correction of shoes when necessary. If tight strapping of the sacro-iliac joint gives relief, then a properly fitted sacro-iliac belt may be considered. Some have found that this backache is somewhat related to the sciatic pain and is relieved by the administration of vitamin B.

The subject of the abdominal support is very frequently submitted to the physician. However, an abdominal support is a "crutch" and exercises, not "crutches", are advised to strengthen muscles, whether they are muscles in the leg or the muscles of the abdomen. If we want to strengthen the muscles of the abdomen, so that the abdomen becomes smaller and better shaped, we advise using these muscles and toning them by exercise, if possible. We do not depend on a support.

Sciatic pain is a frequent complaint in pregnancy. This may be found, as in cases where pregnancy is not present, to be associated with the foci of infection. However, vitamin B has definitely been found to give relief in some cases and it may be adminis-

tered to patients intramuscularly or orally as has been previously mentioned.

Calcium deficiency long has been considered the cause of cramping sensations which occur chiefly in the calves of the legs. Calcium, as is known, is most effectively administered on an empty stomach and along with vitamin D. However, vitamin B deficiency also has been found to be connected with muscular pains and for that reason should be borne in mind.

Polyneuritis is a vitamin B deficiency disease with a group of symptoms relative chiefly to the skeletal system. This has been referred to as the neurological symptoms associated with persistent vomiting and always has been considered a serious condition.

The onset may be sudden or gradual.

SYMPTOMS

Pulse rate elevated.

Vagus nerve disturbances.

Weakness—legs more than arms, extensors more than flexors.

Reflexes exaggerated.

Deep muscle tenderness; bed clothing painful (calves of legs).

High center nystagmus.

Double vision (transient).

Cerebral deafness (can hear but cannot respond).

Mental: Loss of orientation, loss of memory (especially for recent events); confabulation (makes up stories to fill in).

Treatment: Vitamin B—orally or hypodermically.

Emotional and Mental Changes: While the marked emotional and mental changes do not take place during the early part of pregnancy, very frequently a recognition of some of the early signs such as nervousness, mental aversions, unexplained fatigue or exhaustion may give an early warning of later manifestations. The so-called psychosis of pregnancy or the postpartum state is a breaking point of a true psychosis such as schizophrenia, manic-depressive state, etc.

If anything can be done about this condition it is from the same point of general hygiene, advising a completely adequate diet, especially vitamin B, adequate exercise and recreation. Also it should be borne in mind that an early recognition of such symptoms may save trouble later.

Complications Relative to the Genital Organs: These are usually listed as: 1. Cramping and bleeding (which is usually interpreted to mean a threatened miscarriage). 2. Retroversion of the uterus. 3. Ovarian cyst. 4. Fibroid. 5. Ectopic pregnancy.

It is amazing how frequently pregnancy fails to reach full term. It has been estimated that about 19 per cent of pregnancies terminate prematurely. This has been deduced from a large series of cases taking the figures as an average from many observers.

The majority of miscarriages occur during the third month. The percentage by months is as follows:

Month	*Per cent*
1st	0.6
2nd	26.6
3rd	41.9
4th	16.9
5th	7.8
6th	3.2

The causes of miscarriage may be listed as follows:

Faulty impregnated ovum or abnormalities of fetus which are inconsistent with life.

Placental abnormalities:
- Low implantation.
- Imperfect implantation.
- Premature separation.

Abnormalities in genital tract:
- Imperfectly developed uterus.
- Retroversion of uterus.
- Diseases of the decidua.

Acute infections—disease or poisoning.

Dietary deficiencies (vitamin C and K).

Trauma.

Emotional or psychic shock.

Endocrine factors.

Syphilis.

It is interesting to note that two observers

have estimated that from 20 per cent (Abernethy) to 68.6 per cent (Vemucoli) of all pregnancies do not reach full term. There is no adequate explanation for this high percentage of miscarriages. Further investigation is needed in this field.

Treatment of threatened or repeated abortions may be divided into two chief groups or subdivisions: 1. Prophylaxis. 2. Active treatment.

Prophylaxis is very important. It is the physician's responsibility to keep the patient at the peak of physical well being by various methods of hygiene including rest, adequate diet, and wholesome surroundings. It is also definitely his responsibility to investigate any suspected case and to put these cases on active treatment before serious trouble develops.

When actual cramping or bleeding occurs, immediate steps should be taken; bed rest, elevation of feet, sedatives and avoidance of irritation of the bowels with laxatives. The use of morphine and ice bags has been definitely condemned, especially in some clinics. Karnaky reports that stilbestrol given in 25 to 50 mg. doses every fifteen minutes until bleeding and cramping stops, continuing with 10 mg. every hour for six doses and then with a maintenance dose of 10 mg. daily has proved very satisfactory. Thyroid therapy long has been considered a definite help and should be given to tolerance dosage. More recently Stander has advised investigation for possible blood dyscrasias or deficiency of vitamin C and vitamin K and the administration of these drugs when necessary.

The woman with the retroverted pregnant uterus should definitely be considered more susceptible to miscarriage than a woman whose uterus is in normal position. With this in view, certain prophylactic measures are justified. The author has found the routine use of 10 mg. of stilbestrol at bedtime together with regular, tolerance doses of thyroid to be helpful. This should be given during the first three months of pregnancy or until the uterus has assumed its normal anterior position.

Ovarian Cyst: Many consider the presence of an ovarian cyst as an indication for a surgical procedure in the pelvis believing that the cyst may increase the possibility of a miscarriage.

Fibroids, unless large enough to cause some disturbance during delivery, may be left alone.

Ectopic Pregnancy: It is the duty of the physician seeing the woman during the early part of pregnancy to consider the possibility of an extra-uterine pregnancy if there are atypical symptoms.

PREGNANCY AND SYPHILIS

A routine serological test for syphilis should be included in the first examination of the pregnant woman. Many advise that this test be repeated at the end of the seventh month and during the course of pregnancy if symptoms or history suggest the need for such.

It is considered important that adequate treatment be continued during pregnancy unless the syphilitic woman has completed her course of treatment and has remained clinically cured for at least a period of two years, or unless she has had two normal pregnancies since stopping her treatment. It is also considered wise to arrange the course of the treatment so that arsenic in some form, preferably mapharsen, may be given during the last six weeks of pregnancy.

The purpose of the treatment in doubtful cases is for the benefit of the child. It is considered that a fairly good prognosis can be given if satisfactory, continued treatment is carried out and has been started prior to the fifth month of pregnancy.

It is wise to remember several outstanding points in connection with syphilis during pregnancy: 1. The signs and symptoms of syphilis are frequently masked during pregnancy. 2. Syphilis is a killer, especially of the newborn. 3. Consultations are urgently needed at times and now they are easily available by arrangements with the United States Public Health Service. 4. The patient should be given specific instructions as to further

examinations and treatment required, perhaps including a spinal fluid examination after the baby has been delivered.

Medical and Surgical Complications During Pregnancy: Acute infections such as pneumonia or whooping cough should be considered early as a predisposing factor to a threatened miscarriage. With this in view the method outlined under threatened miscarriage should be borne in mind.

Conservation of life must dictate every decision for surgery during pregnancy. If surgery is deemed necessary the proper preparation of the pregnant patient should be made. Some observers report satisfactory results following the use of large doses of stilbestrol, for example, 25 to 50 mg. a day, before surgery and immediately following.

CONCLUSIONS

The complications of early pregnancy which may threaten the life of the mother or the fetus should be recognized promptly and treated vigorously.

Relief from annoying symptoms helps the woman to face the next pregnancy much more calmly.

The use of vitamin B and stilbestrol have been found helpful in treating gastro-intestinal symptoms.

The use of stilbestrol, thyroid and vitamins C and K are recommended in the treatment of threatened or repeated miscarriages.

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CHRONIC FATIGUE

Rest and vacation are the first thing that a physician thinks of in dealing with illness of emotional origin. Probably he recognizes that symptoms are due to external pressures of work or family life which induce emotional conflicts. He thinks first of reducing the pressures. It is felt, and rightly so, that in many instances rest will have a salutary effect. To be given permission by an authority, such as a physician, to give up one's duties and go to bed does much to reduce and remove symptoms.

At about the turn of the century, S. Weir Mitchell achieved fame by prescribing the "rest cure." It worked very successfully because it catered to some of the most basic needs of individuals, particularly psychoneurotics. The patient was removed from the struggle of life and was nursed, massaged, pampered and well fed. In short, he was treated as an infant and all the infantile longings called forth were satisfied. Symptoms do disappear, and in many instances improvement is noted for some time. In many patients frequent repetition of this rest cure is necessary.—Grant E. Metcalfe, M. D., in *The Journal of the Indiana State Medical Association.*

THE MANAGEMENT OF SEVERE BURNS

By W. E. KING, M. D.
Montgomery, West Virginia

THE management of minor burns is not difficult but the problems concerned with the treatment and rehabilitation of patients with extensive third degree burns are numerous and constitute a situation in which all contributions are welcome.

The type of treatment described in this paper, is the result of therapeutic advancements made during the past two or three years.

The chief concern when extensive burns occur is the prevention of primary shock; next, the immediate treatment of the burned area followed by the prevention of secondary shock and toxemia, and finally the rehabilitation of the injured tissue by skin grafting.

PREVENTION AND CONTROL OF SHOCK

The physiology and pathology of shock have been extensively studied and the many contributions as to its successful treatment have played a major part in the lowering of the mortality rate from this cause. Morphine sulfate should be given as soon after the accident as possible and undue exposure and trauma during transportation avoided. Plasma should be administered immediately, beginning with 250 cc. or more and continuing until the hematocrit approximates the normal value of 45 mm. This may require as much as 2,500 to 3,000 cc. of plasma within the first twelve hours. A satisfactory formula has been determined by Harkins which results in giving 100 cc. of plasma for each mm. over the hematocrit reading of 45, or 50 cc. for each 1 per cent hemoglobin over 100. Berkows has also determined that 50 cc. of plasma should be given for each percentage of body surface burned.

The immediate plasma administration combats the blood plasma and protein loss and helps restore the normal circulatory functions, the abnormality of which leads to collapse.

THE AUTHOR

Dr. King, graduate George Washington University School of Medicine, 1939; interned Western Pennsylvania Hospital, Pittsburgh; Laird Memorial Hospital, Montgomery, since 1941, surgical resident.

Should plasma not be available, it is preferable to give whole blood, even though the red cells are superfluous, rather than intravenous saline or glucose solutions which may be detrimental or only temporary in effect.

The value of circulatory stimulants is transient in character. Respiratory stimulants should be given only when respiratory embarrassment is present.

ACTIVE THERAPY

The principle of therapy is to treat the burned area as an injury which is dirty and which is a site of potential infection. If an anesthetic can be avoided it is preferable to do so but there should be no hesitancy in its use when needed. In adults the use of sodium pentothal is ideal when feasible.

The first or emergency treatment at the location of the accident should consist of removal of clothing from the burned area and the application of plain sterile dressings. Over large burned areas the various greasy ointments are a detriment since they must be removed when actual treatment is begun.

Mechanical cleansing of the burned area should be done under aseptic precautions as in any other surgical procedure. Scrubbing with sponges or a soft brush, using copious amounts of tincture of green soap followed by saline irrigations should be done, after which all loose tissue is debrided. The application of bactericidal solutions is to be condemned as it has been shown that their action

is detrimental to the already damaged tissue.

After thorough mechanical cleansing, allantomide ointment may be applied to the burned area. This ointment contains 10 per cent sulfanilamide and 2 per cent allantoin in a greaseless base. The allantoin is an agent which has for its purpose the chemical debridement of necrotic tissue and stimulation of cell growth.

This ointment is overlaid with vaseline gauze followed by numerous sterile gauze dressings and then a firm pressure bandage is applied, using four inch heavy mesh gauze roller bandage. The pressure bandage principle which has been described by Siler, has the primary function of preventing the escape of serum and exudate from the injured site.

Efficacious treatment has been reported by the similar use of 5 per cent sulfathiazole ointment and sulfadiazine preparations.

Fig. 1. Entire thigh and leg involved. Approximate body surface involved 16 per cent. Photo five weeks after burn and skin grafts growing.

This therapy is thought to be superior to the use of tanning agents or of dyes because it is not as time consuming and there is less likelihood of concealed infection being present. The necessity of removing the escharotic membrane prior to skin grafting is also obviated.

The toxic reactions which may occur from the administration of sulfonamides must be watched for when this method of therapy is employed as blood concentration occurs by local absorption and may cause the same toxicity as if taken orally. Blood sulfanilamide concentration of 3 mg. was determined in one case from application of sulfanilamide to approximately one-half the thigh and gluteal area.

Fig. 2. One-half of thighs bilaterally involved. Approximate body surface involved 10 per cent. Photo eight weeks after burn. Skin grafts growing.

If septic complications do not occur within forty-eight to seventy-two hours it is desirable to allow the primary dressings to remain intact for a period ranging from six to eight days before redressing or the institution of hot saline compresses.

SECONDARY SHOCK

After therapy of the lesion has been instituted, continued observation and further treatment are required to combat secondary shock, a danger which persists for many hours. To maintain a satisfactory circulatory mechanism, continued hematocrit determinations are necessary to ascertain the need of more plasma or blood.

General supportive measures are used and adequate fluid intake is maintained for which it may be necessary to administer intravenous

fluids after the vessel walls have recovered from their abnormal permeability.

Oxygen is valuable as an adjunct to a persistently poor circulatory state.

Adrenal cortex is used by some physicians and it has been shown that by its use the abnormal capillary permeability is restored to the normal within a period of eighteen hours instead of the forty hours without its use.

TOXEMIA

The condition of the patient must be watched for evidences of toxemia which usually occurs within twenty-four to seventy-two hours. The febrile reaction, urinary output and nitrogen levels must be closely observed. Satisfactory urine output must be maintained and if there is not sufficient intake orally, supplemental intravenous fluids must be administered. Blood chlorides, urea nitrogen, icterus index, prothrombin time, and total blood proteins are the determinations which usually give adequate information as to renal function, liver function and general condition of the patient. Blood transfusions to support lowered blood proteins or a lowered hemoglobin are of value at this stage.

Fig. 3. Left axillary region extending into anterior and posterior chest and down the inner aspect of arm and forearm. Approximate body surface involved 17 per cent. Photo twelve weeks after burn. Skin grafts growing.

Following this regime, adequate circulatory stabilization having been obtained, attention must be directed toward the detection of any signs of a septic course due to excess infection at the site of the burn.

REHABILITATION

When the primary dressing is removed, hot saline compresses may be started in order to prepare the site for skin grafting. A period of from two to five days may be required before the area is free of all necrotic debris and sufficient vascularization and healthy granulation have appeared to indicate a satisfactory recipient site. It is felt that the quicker the recipient site can be prepared for skin grafting the better the subsequent results. We have found pinch grafts to be satisfactory and their use frequently permits an earlier institution of skin grafting. The most satisfactory donor sites are the thighs, lower abdomen and chest where the skin is thin. Numerous articles have appeared in the literature during the past two years giving the indication and technic of the various types of skin grafting.

The success of skin grafting is also dependent on the general condition of the patient which should be at the optimum with as normal a blood picture as possible. Vitamin therapy is thought to be a valuable adjunct in preparation of the patient, especially supplementary administration of vitamin C and the B complex.

Figures 1, 2 and 3 are patients treated by the outlined regimen with pinch grafting technic employed for rehabilitation.

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HALF OF DEATHS UNNECESSARY

Each year about 41,000,000 souls leave this planet and a somewhat larger number arrive. Of these deaths, more than twenty million each year are quite unnecessary, and will be prevented as soon as modern civilization (including enough to eat) reaches everywhere.—*Science Digest*.

Tuberculosis Abstracts

Furnished Through the Courtesy of the West Virginia Tuberculosis Association

Our national experience with tuberculous veterans of the last war has been unfortunate. Sadder still would be a repetition involving the men and women fighting World War II. This paper, addressed originally to health officers, challenges every physician whose practice embraces a tuberculous veteran or the family of one.

Tuberculosis Among Veterans

During first World War inductions, knowledge and facilities for diagnosis were insufficient to screen out many men suffering from tuberculosis, particularly presymptomatic disease. Thus, many active cases entered the Army. Hardships of training and combat produced still more. After the war, care of tuberculous veterans fell to the newly organized Veterans' Bureau. Hospitals and sanatoria were erected. The service became a major medical activity of the Bureau, and of its successor, the Veterans' Administration. As early as 1923, 23,653 tuberculous veterans were admitted to treatment in one year. At first, care was limited to tuberculosis connected with military service. Subsequently, cases with disease unrelated to military service became eligible. As a result, tuberculosis admissions have continued numerous. During fiscal 1942, after almost a quarter century, hospital admissions numbered 9,658. Over 300,000 such admissions and readmissions have accrued in hospitals of the Veterans' Administration or other government, state or civil institutions since the last war.

The government has spared no efforts or funds in erecting and equipping modern hospitals and in providing adequate medical personnel. In March, 1942, there were 5,217 beds to meet current needs, embracing tuberculous veterans of the present war and including tuberculosis beds in veterans' psychiatric hospitals. Besides having all costs of hospitalization and transportation to hospitals paid, tuberculous veterans also receive compensation payments scaled from $8 to $100 per month, based on varying grades of dependency and service-connected or non-service-connected disability. Men treated at home may qualify for an additional $50 per month payable to the wife or other attendant. These provisions have tempted many to discontinue hospital care and attempt a cure at home.

Standards of operation in veterans' hospitals are generous. In 1942, excluding overhead, the per diem cost of operation was $4.37 per patient and the total direct costs of treatment approached $8,000,000. Compensation of World War I veterans with partial or total disability due to tuberculosis, whether or not service-connected, amounted to approximately $40,000,000 during that fiscal year. Such veterans then still numbered 63,000, and exceeded by many times the number accepting hospital care. Disability payments over the last 25 years aggregate about one billion dollars.

Despite the admirable services available to tuberculous veterans, the experience of their hospitals has been unfavorable. Thus, in 1942, of the 9,854 cases discharged from these hospitals, only 1.9 per cent were designated "arrested" at discharge; 0.3 per cent "apparently arrested," and 0.8 per cent "quiescent"—a bare total of 3 per cent medically rehabilitated. The remaining discharges included: "condition improved" 32.7 per cent; "condition unimproved" 28.9 per cent; "dead" 19.5 per cent; and "condition not stated" 16.0 per cent. The vast majority were obviously not ready for release. So-called "improved" cases represent, predominantly, patients with unstable lesions, a large proportion leaving the hospital without authorization or consent. Thus, the Veterans' Administration itself classified the hospitalization of 58 per cent of the cases as "incomplete." These 1942 figures are rather typical, though somewhat worse than those of earlier years.

Exact comparisons among various sanatoria as to results of treatment on the basis of such crude figures are impossible, particularly now when World War I veterans admitted are older men, usually with chronic disease. Of recent admissions, only 4 per cent were "incipient" cases, 22 per cent "moderately advanced," and 74 per cent "far advanced." Even so, there is a painful contrast between the results with veterans and those achieved in well managed state, municipal, and private sanatoria. In a 1933-34 survey of tuberculosis hospitals and sanatoria in the United States by the American Medical Association, patients discharged with tuberculosis "arrested," "apparently arrested," or

"quiescent," accounted for 29 per cent of all discharged. Among Michigan State sanatoria from 1930 to 1934 discharges included 61 per cent in these three groups. At Mount McGregor Sanatorium of the Metropolitan Life Insurance Company, of males discharged between 1919 and 1936, and excluding incipient cases, 48 per cent were in comparable categories. Even for cases far advanced on admission, the proportion was 34 per cent.

This deplorable situation among tuberculous veterans has not developed from lack of desire to help the men. Everyone concerned aimed at optimum care. The chief failure was by legislators and others interested in veteran welfare to appreciate fundamental conditions necessary for effective treatment. In part, outside pressure was brought to bear to liberalize financial provisions. These measures actually have minimized effective control over the movement of the tuberculous. Veterans, not subject to ordinary hospital restrictions, come and go almost at will, regardless of their condition and against medical advice. Patients have been readmitted as many as 24 different times. Six to 8 admissions of the same man are common despite official effort to educate and persuade patients to complete their hospital care, and measures to exclude offenders from immediate rehospitalization. Much of the discipline essential to success in treating tuberculosis is lacking. Indeed, laws and practices have so evolved that it often financially benefits men to leave the hospital or avoid it altogether. This creates an impossible situation, undermining morale of veterans and professional staff alike.

More serious than mere failure to rehabilitate the patient, discharge before cure exacts its toll on the nation. It has allowed thousands with communicable tuberculosis to return to civilian communities, to live at home or travel about under little or no medical supervision. State and local health officers have assumed little responsibility for men traditionally regarded as wards of the federal government. Few patients have recovered; most have constituted an army of discouraged men spreading tuberculosis in their home communities.

Administration authorities and veterans' leaders are recognizing the need for a remedy, beginning with a drastic change in viewpoint. Specific improvements are being considered and necessary legislative measures will be debated. The American Legion is launching a campaign through its local branches to see that veterans resume and continue hospital treatment until discharged with medical approval.

What is to be done? First, new controls must render liberal benefits medically effective, preventing the drifting of tuberculous veterans until the disease is "arrested" or, at least, not a menace.

Second, the medical profession must cooperate with the Veterans' Administration in the follow-up of tuberculous ex-patients. The Administration has indicated that it will release information to state and local health officers, and routines for getting such reports are imperative. Men still in need of sanatorium care who will not stay in veterans' institutions should be hospitalized in state or local sanatoria, with legal power invoked where necessary. Each man's circle of contacts should be thoroughly combed for additional cases.

Finally, a genuine effort must be made to protect the large crop of tuberculous veterans inevitable from the present war. It is likely that the Veterans' Administration will function under regulations and procedures governing the care of veterans of World War I. Already, many of the tuberculous veterans of the new war show the same restlessness and abandonment of hospital care which have produced calamitous results among the older men. With new cases already numerous, the stage may be set for another great medical tragedy. Lack of discipline and mistaken generosity may not only take their toll of young men who deserve to get well and resume useful lives, but may seriously delay control of tuberculosis in the general population—unless we act!

Function of the Health Officer in the Control of Tuberculosis Among Veterans, Louis I. Dublin, Ph.D., Amer. Jour. of Pub. Health, Dec., 1943.

BACK SEAT DRIVING IN REVERSE

A husband drew up his chair beside his wife's sewing machine.

"Don't you think you're running too fast?" he asked. "Look out! You'll sew the wrong seam! Mind that corner, now! Slow down, watch your finger! Steady!"

"What's the matter with you, John?" asked his wife, alarmed. "I've been running this machine for years!"

"Well, dear, I thought you might like me to help you, since you help me drive the car."—*Highway Traveler.*

The President's Page

I am sure all of you have received, and many of you have read, the news of the Association of American Physicians and Surgeons, dated January 22, 1944, sent from Gary, Indiana, to all members of our profession. Truly, it was a remarkable document, and I am sure a great deal may be heard from this organization before many moons have passed.

My own immediate reaction was one of hearty endorsement. But as the days passed and no great commotion seemed to be created among our local brethren, I began to wonder. Such an organization, if extended throughout our land, would certainly constitute a strong pressure group. It truly smacks of C. I. O.-ism. What little dignity remains in our chosen profession would certainly not be enhanced. And then again there is that very strong probability that such an organization is not necessary, and would only further complicate an already complicated picture.

I for one begin to sense a settling down in Washington, and now have hopes that the political desires for the socialization of medicine are very much on the wane. This may be overoptimism on my part, but haven't you all sort of had similar feelings within the past few weeks? I wonder if we as physicians should take a stand, and say that we will practice our profession only as we see fit, or not at all. I wonder!

If only those days of long ago could once more return to our midst, when the family doctor stood on the highest peak in his community, loved and adored by all, father confessor, physician, and friend. They have gone perhaps, but have not been entirely forgotten. So let us remember that we still represent a lofty and noble profession, that our first duty is to our patient, and our country, and last of all to ourselves.

As an afterthought, let me remind you that May is a wonderful month and nowhere is it so lovely as in good old Wheeling, West Virginia. The latch string will be out, and we are looking forward with eagerness to your coming. We expect a grand convention, and with it all a little time for fun, but make your reservations early, for our room space as you know is somewhat limited. Write immediately to either the Windsor or McLure Hotel if you don't want to be disappointed.

President.

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FURTHER TUBERCULOSIS HOPES

The recent articles appearing in lay periodicals on diasone, especially that in the *Reader's Digest* for February, have produced a spate of queries from both laymen and physicians as to this wonder-working (?) remedy. Diasone is the trade name for disodium formaldehyde sulfoxylate diamino diphenyl sulfone. It is a chemical cousin to promin which a few years ago was hailed as a chemotherapeutic specific for the bacillus of Koch, but whose light of hope has gradually dwindled to a faint flicker. The new drug appears to have been synthesized in 1937 by research workers at the Dermatological Research Laboratories in Philadelphia and has been under investigation for some time past. In the correspondence section of the *Journal of the American Medical Association* for February 5, Dr. Charles K. Petter of Lake County (Ill.) Sanatorium, who has been for the past year experimenting with the drug therapeutically by its oral administration to 139 patients, says:

"Diasone is still an experimental therapeutic agent. Much more must be learned about dosage, toxic reaction, change which takes place in the tuberculous lesions and the many other ramifications of such a problem. We cannot be too emphatic at this time in stating that this compound is not ready for even limited distribution until a great amount of investigational work is completed."

The Committee on Therapy of the American Trudeau Society will present a clinical report upon its investigations of diasone in an early issue of the *American Review of Tuberculosis*, and a report by other investigators has been submitted to the *Illinois Medical Journal*, where presumably it will appear in due time.

In the meantime research workers at the Mayo Clinic have been experimenting with another sulfone—promizole. Their work is summarized in the January 26 issue of the *Proceedings of the Staff Meetings of the Mayo Clinic*. This drug, which is a fairly close chemical relative of both promin and diasone, appears to have a therapeutic effect as favorable upon experimentally produced tuberculosis in the guinea pig as either promin or diasone and to be much less toxic for human beings than either of them. Promizole, however, in the experimental animal appears to be goitrogenic, producing diffuse parenchymatous hyperplasia of the thyroid which appears to regress entirely when the drug is discontinued.

So far these workers have experimented clinically by administering promizole orally to 56 patients, to some of them as long as four months continuously. Although the dose is rather large—150 to 240 grains daily—no serious toxic manifestations have been noted. More than 80 per cent of the ingested drug is excreted in the urine which frequently shows a pink color, but no other urinary symptoms have been reported. One case of tuberculous meningitis treated with promizole recovered. Although their work is promising, these investigators with the scientific spirit which pervades everything done at the Mayo Clinic warn against undue optimism. We quote their final paragraph:

"The clinical results of treating tuberculosis by this method cannot be evaluated at this early period of our study. Clinical tuberculosis is so variable and unpredictable in its clinical course and the trend

toward spontaneous healing without treatment is so frequently observed, that errors of judgment would be easy to make. Furthermore, the healing mechanisms in tuberculosis act slowly and are unlike those noted in the acute diseases responding to chemotherapy, and we have no quantitative measure of the activity of lesions of tuberculosis, such as serologic tests afford in syphilis. It is our belief that accurately controlled studies will be required before this or any other therapeutic agent can be evaluated in such a disease as pulmonary tuberculosis. In the meantime conventional modes of treatment must be recommended to patients with tuberculosis, and no hope of immediate prospects of simplified therapy encouraged."

SULFONAMIDES AND URINARY SYMPTOMS

From some hospitals in the state come reports of a noticeable increase in the incidence of sulfonamide crystal formation in the urinary tract following the employment of these drugs in the treatment of influenza. These reports pertain almost entirely to the use of sulfathiazole and sulfadiazine. Sulfanilamide is not much used in this connection and sulfamerazine reports are as yet very infrequent. There is some doubt regarding the effectiveness of the sulfonamides in uncomplicated influenza with the weight of the better opinion to the effect that they are useless.

It is a matter of each physician's judgment how much, if any, of these drugs he should administer to a patient. Accumulative evidence seems to indicate that smaller dosage than heretofore employed may give results, if results are to be forthcoming, with less likelihood of focal renal necrosis and crystal formation. All reports of trouble emphasize the importance of liberal fluid intake, meaning at least 1,500 to 2,000 cc. daily. Urologists have long preached that renal drainage is sluggish in bedfast patients, hence bedpatients taking sulfonamides should be turned frequently and should be kept under fairly close observation.

Pain in the kidney region, diminution in the amount of urine and hematuria, gross or microscopic, indicate immediate withdrawal of the drug. The presence, or absence, of crystals in the urine is of no significance.

Under forced fluid intake and urinary alkalinization most cases respond promptly. Persistent oliguria or annuria call for prompt ureteral catheterization and lavage of the kidney pelves and ureters.

LET'S GIVE

In a communication received from Col. Chas. F. Fisher, of Clarksburg, who was in command of the first American station hospital to land on the European continent, the following observation is made:

"The high spot of Africa is the Red Cross, as every soldier will tell you, no matter where you stop him on earth. It is clean and pleasant. We heard music for the first time and could hear radio news. * * * The greatest thing at the Red Cross was free soap, clean towels, and showers. * * * Anyone who neglects donating to the Red Cross is missing a means of comfort to the soldiers. The thanks of the men should be the interest on their donation."

Those who have made a study of the work of the Red Cross will agree with every word Colonel Fisher has said. The Red Cross is on the job twenty-four hours a day at home and abroad.

When bombs fall there is no time to send help half way around the world. When a badly wounded fighting man needs a transfusion, it is too late to begin looking for a blood donor or find a nurse to care for him. When a lonely soldier learns of trouble at home, he needs help immediately. The American Red Cross provides that help wherever and whenever the need arises.

To fulfill its many obligations to the armed forces and our people, the American Red Cross needs your help. During 1944 it must supply some 5,000,000 blood donations. Each month 2,500 nurses must be recruited for the Army and Navy. Red Cross field directors and other trained presonnel must be stationed at military and naval posts and

hospitals to help our fighting men and their families when personal trouble brews, a task in which the Red Cross chapter on the home front ably does its share.

At home the Red Cross must continue to maintain a state of alert. Disasters must be met as they occur. Nurse's aides and first aiders must be trained and other educational projects continued. When a train crash leaves scores injured, when flood engulfs a town, when epidemic strikes, delay may cost lives. Red Cross disaster relief and medical supplies, held in readiness for such emergencies, plus trained workers to rescue and assist victims and help in their rehabilitation, will prevent delay and thus save many lives.

All activities of the American Red Cross are financed by voluntary gifts and contributions. During March, designated by President Roosevelt as Red Cross Month, the American Red Cross must raise its 1944 War Fund of unprecedented size to meet unprecedented needs. West Virginia's quote is $1,543,400. Your contribution will assure maintenance of all Red Cross services and thus indirectly help save many lives. *Let's give!*

WAR ON CANCER

The appointment of Dr. Paul R. Gerhardt, of Charleston, as director of the division of cancer control in the state health department will meet with the hearty approval of the members of the medical profession. The delay in getting the division set up and in operation has been unfortunate, but unavoidable. No effort will now be spared to speed up the work so that West Virginia may take her place with eleven other states which have bureaus or divisions operating under a specific cancer law.

For the past two years, Dr. Gerhardt has served as director of the bureau of medical services in the department of public assistance. His services as directing head of programs dealing with crippled children and adult physical rehabilitation have been outstanding. He is energetic and most thorough in his work and has the respect and confidence of all who are in the least familiar with the many problems he has had to meet and solve.

DR. PAUL R. GERHARDT

Dr. J. E. Offner, state health commissioner, and the members of the public health council are to be commended for their selection of Dr. Gerhardt for this work, and the people of West Virginia are to be congratulated for having at the head of this important new division an official so well qualified to organize the state, county by county and community by community, for a relentless war against a disease which it is estimated takes an annual toll of over 1,500 lives in West Virginia.

THE TRUSTEES' MESSAGE

The Journal of the American Medical Association, in the issue of January 29, presents to the profession a sane, sober and thought-provoking message from the Board of Trustees. Their statement is so clear cut and so apropos that we are glad to reproduce it in its entirety:

"For some ten years the physicians of the United States have been subjected to a series of stresses such as have disturbed the orderly progress of medical science in no previous period of similar length. In 1860 Oliver Wendell Holmes wrote:

" 'The truth is that medicine, professedly founded on observation, is as sensitive to outside influences, political, religious, philosophical, imaginative, as is the barometer to the changes of atmospheric density.'

"The depression of 1929, the evolution of the Social Security Act, the first Wagner bill, the development of hospitalization and medical care insurance, the enrollment of a third of the active medical profession in the armed forces, and now the Wagner-Murray-Dingell bill represent a series of provocative crises. Each of these challenges was met by the House of Delegates, the Trustees and the officers of the Association with clearly defined statements of policy which the Association has disseminated widely. Under these policies the extension of medical service has proceeded steadily and everything possible has been done to maintain the quality of medical education and medical service at the high standard that has been our ideal. The continued pressure of the years has been climaxed by the Beveridge report, the report of the National Resources Planning Board and the introduction of the Wagner-Murray-Dingell bill. This comes when every physician not in the armed forces is giving of himself unstintedly without thought of time or physical capacity.

"Today strange social philosophies pervade the radio, the press and the periodicals. Panaceas for medical problems are proffered by innumerable prescribers. Some preach distrust of medical organization, cast doubt on the loyalty of our leaders, sow dissension in our membership! These activities are no doubt a reflection of anxieties and fears. And they appear at a time when a united, loyal, solidly organized medical profession is more needed than at any previous time in our history! When our representatives appear before legislative hearings they are entitled to the loyal, enthusiastic, unified support of the constituent and component societies of the American Medical Association.

"In some areas there are attempts at reorganization of the county medical society on a strictly business basis; attempts are being made to organize small groups of the states into sectional cliques; before the House of Delegates of one state a delegate actually urged a united opposition to the Southern states; here and there physicians, apparently inspired by lay employees or by the urging of outside agencies, would pour the funds of county and state medical societies, swollen by special assessments, into 'public relations,' as if this were some new and potent magic; there are occasional demands that the medical profession "unionize" and affiliate with one or the other of the major labor organizations. * * *

"Now what are the facts? The trend of public thought is quite definitely against any such expansion of the Social Security Act as the Wagner-Murray-Dingell bill contemplates. The Council on Medical Service and Public Relations has been organized, has developed a program, has stated its policies, has secured a full time secretary, has expanded sources of information on legislative activities, is participating in public relations for the Association. The Board of Trustees has organized for suitable representation at any hearings that may be called on legislation affecting the medical profession. The publications of the Association have reached the highest peak in their history in circulation and effectiveness. A poll proves that a majority of Americans interviewed consider the American Medical Association an organization interested in the advancement of medical science, an organization devoted to the approval of that in medicine which is sound and exposing that which is fraudulent—what the experts call a 'favorable symbol.' And all this accomplished at a time when the employees of the Association have been reduced by one-fourth by war activities or call to the armed forces, and when many others are likewise giving largely of their time to war activities.

"The Board of Trustees pledges itself anew, as do the officers and employees of the Association, to do their utmost to carry out and to implement the principles, the policies and the mandates of the House of Delegates. To some 55,000 physicians who are in the armed forces the Board pledges all that the Association can do to maintain for them a medical profession free from the interference of political control. The Board is convinced that the House of Delegates will also do its utmost to hold the traditions of Americanism and American medicine inviolate until the physicians who are now with the armed forces return and themselves participate in determining the future of American medicine."

This is a message every doctor may well "read, mark, learn, and inwardly digest." It is to be feared that the rank and file of the profession do not appreciate properly the efforts and accomplishments of the trustees. These loyal servants of the profession give unstintingly of their time and talents to implement the policies enunciated by the House of Delegates, and this ringing message should stimulate us to keep even keel and level heads, and to think through the implications of all proffered innovations in medical practice before getting in a swivet about adopting any of them.

General News

DR. PAUL R. GERHARDT APPOINTED HEAD DIVISION OF CANCER CONTROL

Dr. Paul R. Gerhardt, of Charleston, has been appointed by Dr. J. E. Offner, state health commissioner, as director of the new division of cancer control. The appointment was made under the provisions of an act passed at the 1943 session of the legislature. The act authorizes the commissioner to appoint the director in consultation with the public health council.

The division is authorized to set up cancer diagnostic and treatment clinics in hospitals meeting certain standard minimum requirements. In the establishment and operation of such clinics, the division is to consult and cooperate with the West Virginia State Medical Association. Free diagnostic service and treatment is to be furnished needy patients within the limits of funds available for the purpose.

While the bill creating the division was signed March 19, 1943, by Governor Neely, long an advocate of state and federal legislation, to provide for the treatment, control and cure of the disease, the state health commissioner has experienced a great deal of difficulty in finding a qualified physician interested in accepting the appointment. The acute shortage of doctors, due to the enlistment of so many for service with our armed forces, has sharply limited the field of physicians available for this type of work.

With the appointment of Dr. Gerhardt as director, it is now thought that the division will be in full operation within the next two weeks. An appropriation of $50,000 per annum for the use of the division was made by the legislature in 1943.

Dr. Gerhardt has served as head of the bureau of medical services in the Department of Public Assistance for the past two years. As such, he has directed the department programs for crippled children and adult physical rehabilitation. Prior to that time, he was engaged in industrial practice at Van, Boone county. He is a graduate of the University of Wisconsin Medical School, and was licensed in West Virginia in 1938. He is a member of the American Medical Association, the State Medical Association, and Kanawha Medical Society.

KANAWHA APPROVES PLAN

The Kanawha Medical Society has approved the medical-surgical plan now being administered in the Charleston area by Medical Service, Inc. The plan conforms with the basic contract approved for the use of component societies by the Fact Finding and Planning Committee of the West Virginia State Medical Association.

The resolution formally approving the local plan provides that a committee from Kanawha Medical Society work with the board of directors of Medical Service, Inc., in an advisory capacity, and recommends that the fee for medical visits in hospitals be increased to $3 as soon as it is reasonably possible to do so. The plan now provides a fee of $2.50 for such visits, which are limited to one per day.

DOCTORS LICENSED TO PRACTICE

As a result of the examination for licensure conducted by the Public Health Council at Charleston, January 3-5, 1944, fifteen doctors have been licensed to practice medicine in West Virginia, nine by examination and six by reciprocity.

The following doctors were licensed by examination: Robert C. Aliff and Warren S. Carter, Charleston; Lt. Frederick E. Amick (MC), Richwood; James C. Batten, Parkersburg; Robert J. Fleming, Morgantown; Lt. (jg) William E. Gilmore (MC), USNR, Wheeling; John A. Stewart, Little Otter; and, Eugene H. Vachon and Ralph U. Whipple, Elkins.

Physicians licensed by reciprocity were Forrest L. Blair, Parkersburg; William P. Boger, Jr., Bluefield; John J. Lawless, White Sulphur Springs; John H. Rentschler, Parkersburg; and, Haven M. Perkins and Joseph P. Seltzer, Charleston.

The next meeting of the Public Health Council will be held at Charleston, May 1-3, 1944.

SAFETY CONFERENCE MARCH 23-24

Dr. Arthur Girard Cranch, of New York, industrial toxicologist for Union Carbide, and Dr. Philip Joseph Lopresti, of Bethesda, Maryland, assistant surgeon of the USPHS, will be guest speakers at a state-wide safety conference in Charleston, March 23-24. The meetings, which will be held at the Daniel Boone Hotel and Shrine Mosque, will be open to the public. The conference is sponsored by state, federal, industrial and civic groups.

CHARLESTON HOST TO FIFTH STATE ASSEMBLY OF WOMEN'S FIELD ARMY

The Fifth State Assembly of the West Virginia Division of the Women's Field Army of the American Society for the Control of Cancer will be held March 2-3, 1944, at the Daniel Boone Hotel, Charleston. The meeting will be in charge of Mrs. John S. Harvey, of Huntington, state commander, and Mrs. A. A. Seletz, of Charleston, deputy state commander.

The assembly will open with a dinner meeting Thursday, March 2, at 7 P. M. The program follows: Address of welcome, Mrs. John S. Harvey; introduction; salutation by Hon. M. M. Neely, governor of West Virginia; message from the A. S. C. C., Mrs. Harold V. Milligan, national commander; "The Diagnostic Tumor Clinic," Dr. Chauncey B. Wright, of Huntington, chairman of the state executive committee of the Women's Field Army; "The Cancer Control Division of the State Health Department," Dr. John E. Offner, state health commissioner; and, "The Function of the Public Health Council," Dr. Walter E. Vest, president, Huntington.

The principal address of the evening will be delivered by Mr. J. Louis Neff, executive director of the American Society for the Control of Cancer. His subject will be "Organizing the County for Cancer Control." Mr. Neff was formerly executive secretary of the Nassau County (N. Y.) Medical Society. He was one of the founders of the Nassau County Cancer Committee, of which organization he served as secretary for fifteen years. He is a fellow of the American Public Health Association and a member of the public health education section of that organization.

The second session is scheduled for Friday, March 3, at 9:30 A. M., with Mrs. Harvey and Mrs. E. L. Goldsborough, of Shepherdstown, presiding. Besides reports of officers and committees, addresses will be delivered by Mrs. Goldsborough, Mrs. Otis G. Wilson, of Huntington; Mrs. W. R. Showacre, of Fairmont, and others.

Mrs. Harold V. Milligan, national commander of the Women's Field Army, will be the guest speaker at the luncheon on March 3. Announcement of distinguished service citations will be made at the luncheon.

An invitation to attend all sessions of the assembly has been extended by Mrs. Harvey to the members of the medical profession in West Virginia.

POLL OF STATE DELEGATION ON WAGNER-MURRAY BILL COMPLETED

Letters from Senator Chapman Revercomb and Congressman John Kee concerning their attitude with reference to the Wagner-Murray bill were received at the headquarters offices of the State Medical Association after the February issue of THE JOURNAL had gone to press. Communications from six of the eight members of the West Virginia delegation in Congress were reproduced in that issue.

To complete the record, the letters from Senator Revercomb and Congressman Kee are printed in their entirety:

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES

Washington, D. C.

January 24, 1944.

Mr. Charles Lively,
Executive Secretary,
West Virginia State Medical Association,
Charleston, West Virginia.
Dear Charley:

During the lifetime of former Vice President Marshall, in a speech he made down in West Virginia, he discussed our entrance into World War 1. He said: "Some people say that we should have entered the war immediately after the sinking of the Lusitania. I don't know. Often we cannot know the best course of procedure without having all possible light on the situation. For example, knowing, as I do, the consequences, I think it probable that, had I been Adam I would never have eaten that apple. But, I have never seen Eve. Perhaps had I been there and had seen Eve, I might have eaten a bushel."

Now, although I have seen and read the bill to which you have referred in your recent letters, I have had no opportunity to study its provisions nor to determine the probable consequences of its enactment.

I am frank to say that should I be called to vote on the measure tomorrow, I would probably oppose it—simply because I would consider it safer to defeat a controversial proposal rather than to take a chance of enacting into law something possibly inimical to the public interests. That is not the way however for any legislator to pass on proposed legislation. However, there is no slightest possibility that I or any member of the House will be called upon to pass on this measure either tomorrow or for many, many other tomorrows. The bill is not before us. In fact it is not out of committee. There is no indication that it will be reported either soon or ever. So, why worry?

At this time all of us are busy in the great effort to win the war. Congress is also tackling the problem of winning the peace and establishing post-war security in a troubled world. Today the House will vote on a measure to implement the international agreement recently entered into by our country and forty-three other nations establishing the United Nations Rehabilitation and Relief Administration. This vote is being taken after the measure had been considered since last July by our Foreign Affairs Committee and after many weeks of public hearings. We

are now living in a world of rapidly changing conditions. There may come changes vitally affecting every line of endeavor and every walk of life. If these changes are made through legislation, then every bill or measure proposing such changes should be given the utmost in study before enactment.

The legislation proposed by S. 1161 is no doubt vitally important in its anticipated effect on a large part of our citizenship. This is all the more reason why the measure should be studied, understood and no hasty conclusion reached. In view of the present status of the bill, we are going to have all the time, and more, necessary to acquire an understanding of it. In fact, by the time it gets to the floor of the House, if ever, it may be a new or an entirely different measure. I feel strongly that for any legislator, under present conditions, to stamp this measure with either his unqualified approval or disapproval would evidence anything else but statesmanship.

If you have occasion to come to Washington I will be very happy to see you. I assure you that my office has "welcome" on its door mat and there is no ban on discussions.

With all good wishes and kindest regards, I am

Your friend,

JOHN KEE.

UNITED STATES SENATE

COMMITTEE ON MILITARY AFFAIRS

January 22, 1944

Mr. Charles Lively
Executive Secretary
West Virginia State Medical Association
Charleston, West Virginia

Dear Mr. Lively:

I have your letter asking an expression on my views on Senate Bill S. 1161, generally known as the Wagner-Murray Bill.

It is, of course, impossible for me to state with certainty how I shall vote upon any particular bill, because I will not know of its final provisions until it is presented for vote on the floor of the Senate.

I take it that you are personally interested in the effect of this bill upon the control of the practice of medicine by the federal government and the control of physicians and surgeons in the practice of medicine.

I do not hesitate to say to you that I am definitely against any control by government that would prevent persons from selecting their own doctors or that would interfere with doctors in the freedom of practice of their profession, or that would destroy the very close personal relation that exists between doctor and patient.

Such a control, in my opinion, would not only interfere with freedom of practice by the doctor, but it would destroy a relation with the patient which is very important to the welfare of the patient.

I may say to you that I took the floor of the Senate last month, prior to the recent recess of the Congress, and opposed an appropriation of money by the federal government to pay doctors to move into communities (Ed: W. Va. M. J., Feb., 1944, p. 60).

It is my present position that I am opposed to socialization of medicine or the socialization of any profession or endeavor.

Very truly yours,

CHAPMAN REVERCOMB.

CR:ms

CHANGES IN APO AND FPO ADDRESSES

Major Pat Tuckwiller, MC,
APO 813,
c/o Postmaster, New York, N. Y.

Major Claude B. Smith, MC,
APO 651,
c/o Postmaster, New York, N. Y.

Lt. Owen A. Groves, MC,
APO 9433,
c/o Postmaster, New York, N. Y.

Capt. John E. Echols, MC,
APO 9554,
c/o Postmaster, New York, N. Y.

Capt. Leonard M. Eckmann, MC,
APO 9492,
c/o Postmaster, New York, N. Y.

Capt. J. C. Huffman, MC,
APO 813,
c/o Postmaster, New York, N. Y.

Capt. L. J. Pace, MC,
APO 553,
c/o Postmaster, New York, N. Y.

Capt. Herbert N. Shanes, MC,
APO 9190,
c/o Postmaster, New York, N. Y.

Capt. James T. Asch, MC,
APO 4,
c/o Postmaster, New York, N. Y.

Major Spencer L. Bivins, MC,
APO 552,
c/o Postmaster, New York, N. Y.

Col. Chas. F. Fisher, Capt. Wm. H. Allman, Capt. Jos. D. Gilman, Major Robt. J. Humphries, Lt. Col. Robt. H. Jones, Lt. Col. Robt. W. Lukens, Major John F. McCuskey, Capt. Paul L. McCuskey, Capt. R. B. Nutter, Capt. Karl L. Van Horn, Capt. Samuel Weisman (all MC),
APO 389,
c/o Postmaster, New York, N. Y.

Capt. Hyman Ashman, MC,
APO 956,
c/o Postmaster, San Francisco, Cal.

Capt. Philip L. Becker,
APO 301,
c/o Postmaster, San Francisco, Cal.

WEST VIRGINIANS ELECTED TO ACP

Two candidates from West Virginia were elected to the American College of Physicians during 1943.

Dr. Reginald Campbell Edson, former assistant superintendent of Hopemont Sanitarium, was advanced to fellowship April 4. He had been elected to associateship in 1940. Dr. Edson is now serving as assistant director of tuberculosis control for the state of Connecticut.

Lt. (jg) Heyes Peterson (MC), USNR, of Wheeling, was elected to associateship November 20. Lt. Peterson is assigned to the Harriman Naval Convalescent Hospital, at Harriman, New York.

RELOCATIONS

Dr. Edda Von Bose, formerly of Alderson, who has been on the staff of The Women's Hospital, Philadelphia, has located for the practice of medicine at San Antonio, Texas.

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Dr. Edwin C. Lane, of Mallory, has relocated for the practice of his profession at Ypsilanti, Michigan.

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Dr. C. E. Peery has moved from Sobato to Sprigg, Mingo county.

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Dr. John Q. Godbey has located at Wevaco, in Kanawha county. He formerly lived at Chesapeake.

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Dr. B. D. Smith, who has been located at Omar for several years, has moved to Amherstdale.

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Dr. W. P. Hamilton has moved his offices from Logan to Chapmanville. He will continue to serve as part-time health officer for Logan county.

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Dr. Richard B. Engle, of Slab Fork, has moved to Beckley, where he is attached to the staff of Raleigh General Hospital.

ATTEND CHICAGO MEETING

Dr. Edward J. Van Liere, dean of the School of Medicine, West Virginia University, Morgantown, and Dr. Walter E. Vest, president of the Public Health Council, attended the Fortieth Annual Congress on Medical Education and Licensure, February 14-15, at Chicago.

WASHINGTON OFFICE PROPOSED

The Eighteenth Annual Meeting of the National Conference on Medical Service, held at Chicago, February 13, went on record as strongly urging the Council on Medical Service and Public Relations of the American Medical Association to establish an office of information in Washington, D. C.

GRADUATES IN AVIATION MEDICINE

Captain Robert M. Lamb, MC, of Winona, has graduated from the School of Aviation Medicine, at Randolph Field, Texas, according to the *Journal of the American Medical Association*. Graduating exercises for the class of which he was a member were held at Randolph Field early in January.

NEW HEALTH OFFICERS

Dr. Ward L. Oliver, USPHS, of Cobleskill, New York, has been appointed health director of District No. 3, with headquarters at Point Pleasant. He succeeds Dr. Blinn A. Buell, who has been transferred to Portsmouth, Virginia. The district is composed of Jackson, Mason, Putnam and Roane counties.

Dr. Harold B. Young, of St. Marys, has been appointed by the county court of Pleasants county as part-time health officer for that county.

CONGRESS ON INDUSTRIAL HEALTH

The Sixth Annual Congress on Industrial Health was held February 15-16 at the Palmer House, Chicago. The following doctors from West Virginia attended the sessions: J. J. Brandabur, Huntington; M. E. Becker, Morgantown; C. S. McKinley, Charleston; and, J. L. Patterson, Holden.

POSTWAR TRAVEL PLANNING

While 1944 is not likely to see the resumption of pleasure travel on a very extensive scale, recent travel statistics at least offer hope to the future tourist.

The inveterate traveler, at present absorbed in war work, may take heart, for travel lanes of the world are being rapidly extended as war supplies are delivered to stations once mere dots on the map. He will enjoy wider horizons and faster schedules when he again goes pleasure cruising.

Air schedules proposed for 1948, and earlier, from New York, include 2 hours and 40 minutes to Bermuda; 8 hours and 12 minutes to Mexico City; 13 hours and 48 minutes to London; and 23 hours and 12 minutes to Cairo. Proposed trips across the Pacific, the Atlantic, and the Mediterranean appear like ferry rides.

Some 429,000 persons traveled to Europe from the United States in the record travel year of 1937, to say nothing of those journeying to other places, near and far. Now with buses about to sprout helicopters, plans for more airplanes and larger capacity ships with greater speed, the number of eager Marco Polos who, come peacetime, will take to the world's travel trails cannot be estimated. Then, too, keep your eye on the new "jet" engine for greater private air travel and cheaper automobile transportation.—*New York State Journal of Medicine.*

WITH DOCTORS IN THE SERVICE

"We are all interested in what is going on back home and in knowing how the profession is meeting the problems that are coming up," writes Captain Franklin B. Murphy, of Philippi, from somewhere overseas. "It seems that you have a big job to do and that you are making good headway with it. Keep up the good work. I am receiving THE JOURNAL regularly and get a lot of enjoyment reading it."

Continuing, Captain Murphy says that "the Medical Department is staying on the ball over here. When I get a chance to visit the hospitals I am very much impressed with the type of work that is being done. The results are really amazing. I would like to tell you about some of the records that are being made, but of course am not permitted to do so at this time."

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Captain Robert R. Frye, of Mannington, who has been stationed at Fort Bragg, North Carolina, is now assigned to the Station Hospital at Camp Sutton, N. C.

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Captain Julius L. Boiarsky, of Charleston, who has been stationed at Camp Atterbury, Indiana, for several months, has been assigned primary duty as post surgeon at Jefferson Proving Grounds, Madison, Indiana. Mrs. Boiarsky and the children have joined him, and they will occupy a house on the post.

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Capt. G. M. Harsha, of Sistersville, who has been stationed at Fort Jackson, South Carolina, is now assigned to the Station Hospital at Camp Blanding, Florida.

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Lieutenant (jg) Heyes Peterson (MC), USNR, of Wheeling, is assigned to the Harriman Naval Convalescent Hospital, at Harriman, New York. He was formerly stationed at the U. S. Naval Hospital, Quantico, Virginia.

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Lieut. W. D. McClung (MC), USNR, of Richwood, has completed his training at the School of Aviation Medicine, Pensacola, Florida, and is now assigned to the medical department at the Naval Air Center at Hampton Roads, Virginia.

Comdr. J. K. Stewart (MC), USNR, of Wheeling, who has been stationed at Quantico, Virginia, since 1942, is serving with the armed forces somewhere overseas.

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Captain W. L. Cooke, of Charleston, has been transferred from Camp Shelby, Mississippi, to the 71st Evacuation Hospital, at Camp Adair, Oregon.

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Lieutenant W. L. Neal, of Huntington, is assigned to the U. S. Naval Hospital, at Corona, California.

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Lieut. Comdr. Charles S. Duncan (MC), USNR, of Huntington, is now stationed in New York City. His address is 111 W. 16th Street.

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"We have a live medical organization here in the European Theater of Operations," writes Major Arnold Wilson, of Welch. "We call it the American Medical Society. Yesterday, I rode a hundred miles in sheets of driving rain to attend a meeting. This is a long trip in an army vehicle."

Major Wilson enclosed a copy of the program in his letter. It is noted that Sir Arthur Hurst, consulting physician to Guys Hospital, London, was one of the speakers. His subject was "Fact and Phantasy in Diagnosis and Treatment." He traveled extensively in America a few years ago.

Major Wilson concludes with this local note: "West Virginians here are fine. Their pet peeve is that our best radio won't pick up that good old McDowell County hillbilly music."

* * * *

Major Ewen Taylor, of Huntington, V-mails from North Africa as follows:

"I have been in this country for 14 months and have been pretty fortunate in the type of set up afforded me.

"Our hospital is a former girls' school, overlooking the beautiful blue Mediterranean. The officers live in an Italian villa, which is supposed to have been the former consul's home. We have palm, orange, tangerine, lemon and even banana trees. We have hot and cold water and practically all the comforts of home.

"During the Tunisian and Sicilian campaigns we were very busy, but have 'coasted' during the present Italian invasion.

"I have seen two West Virginia doctors, Regis F. Downey and a Captain Cohen, both stationed nearby. Major Russell Cook, of Huntington, was through here a few days ago, but is now in Italy."

LIBRARY OF THE
COLLEGE OF PHYSICIANS

"Through the pages of THE WEST VIRGINIA MEDICAL JOURNAL, I am able to keep abreast of the medical times," writes Capt. Grover C. Hedrick, of Beckley, who is stationed in Italy. "The State Medical Association," he says, "shows all the ingenuity of a progressive organization, of which I am very proud to be a member. The scientific articles in THE JOURNAL are well chosen, and I can make use of much of what I read in my practice in the army."

Captain Hedrick has traveled widely in Italy, vititing Naples, Foggia, Bari and Taranto. He says that while looking up one of his patients, he was delighted to find him in the station hospital of which Col. Charles F. Fisher, of Clarksburg, is the commanding officer.

* * * *

Captain Norman Friedman, MC, who prior to being commissioned in the Army, was associated with Dr. M. A. Moore, of Longacre, has been awarded the Distinguished Service Cross, "for extraordinary heroism in the face of intense enemy fire on New Georgia Island." The award was made by order of the Commanding General of the Armed Forces in the South Pacific at a ceremony held within the perimeter of the Empress Augusta Bay beachhead on Bougainville Island.

Captain Friedman was cited for his actions on New Georgia Island, where during the battle for Munda airfield he was exposed to enemy fire in an effort to give medical assistance to wounded men. On Dibela Hill, he was struck and momentarily stunned by shell fragments as he advanced to the aid of a casualty. He continued forward, reached a mortally wounded officer, and then went to the aid of men in the vicinity who were less seriously injured. He succeeded in reaching another officer, and, after treating him, directed his evacuation. In the same fire-swept area, he treated and directed the evacuation of a number of wounded from another regiment.

Captain Friedman has recently been appointed assistant regimental surgeon for the infantry regiment of which he is a part. He has seen service on Guadalcanal and Bougainville. In addition to his other duties, he assisted in the making of training films concerning medicine in combat. These films were made almost within view of the enemy, thus assuring an accurate documentary record of the treatment of casualties in the field.

* * * *

"The unit from my school, the Medical College of Virginia, has been in Africa and is now here in Italy. I take talked with many of my former teachers, classmates and other alumni." So writes Captain Robert M. Ferrell, of Webster Springs.

Captain Ferrell has been overseas since May, 1943, serving in North Africa and then, as he says, "attending the reception in Italy." He reports that living conditions are not too good at times, but that "we are all working in the hope that the war will end soon so that we might return home." He says that he receives THE JOURNAL regularly and reads it from cover to cover. He asks especially to be remembered to his friends in West Virginia.

* * * *

Dr. D. C. Ashton, of Beckley, who is stationed at the Army and Navy Hospital at Hot Springs, Arkansas, was recently promoted to the rank of Lieutenant Colonel.

—Photo by Belfast News-Letter, Ltd.

Tea at the House of Parliament, Belfast, North Ireland, January 3, 1944, with Sir Basil Brook (center), Prime Minister of Ulster, as host. Captain John C. Condry (MC), of Charleston (fourth from left), was in Belfast at the time attending a course in medicine and surgery at Queen's University.

Lieut. John N. Marquis, MC, USNR, of Charleston, has been cited by Admiral Wm. F. Halsey, USN, for courageous conduct during the landing on Treasury Island in October, 1943. The citation is as follows:

"For meritorious performance of duty while serving as a medical officer on board a tank landing ship during the initial landing on Treasury Island last October 27, 1943. Lieutenant Marquis distinguished himself by his foresight and efficient planning for the care of the wounded during the operation. He stayed with the wounded and gave first aid under extremely adverse circumstances. Later, he performed many major operations on the seriously wounded for a period of forty-eight hours with little rest, during which time his ship was under enemy fire from the beach and later attacked by enemy planes as they were retiring. His couragous conduct was in keeping with the highest traditions of the United States Naval Service."

According to an Associated Press dispatch from the South Pacific, Lieutenant Marquis and Lt. Commander Tracy D. Cuttle, of Philadelphia, displayed remarkable ingenuity during the landing on Treasury Island just prior to the attack on Bougainville. By cutting holes in the deck of their ship, it was possible to lower the wounded into wards that had been set up around an emergency operating room. This made it unnecessary to transfer equipment to the beachhead and at the same time afforded means of treating the wounded enroute to a hospital. Lt. Marquis and Lt. Commander Cuttle performed 15 major operations and administered 120 units of blood plasma in a 46-hour period while the ship was under way.

Doctor Henrietta L. Marquis, of Beckley, wife of Lt. Marquis, is now in practice at Beckley.

CAPT. CLAYTON CALVIN CARSON, MC

The first death among West Virginia doctors in the military service occurred February 14 when Captain Clayton C. Carson, MC, of Gassaway, was killed in a motor accident at Camp Butner, North Carolina. An army truck in which he was enroute to field duty skidded on a slippery road, overturned and crushed him beneath the wheels. He had held a commission in the army since November, 1942, and before being assigned a few days before his death to the 27th Quartermaster Service Battalion, had been stationed at Fort Jackson, S. C., and Fort Meade, Maryland.

Captain Carson was born at Charleston, December 17, 1900. He received his education at West Virginia University and Jefferson Medical College, Philadelphia, graduating from the latter institution in 1925 with the degree of M. D. He interned at Charleston General Hospital, and was licensed in West Virginia in 1926. He had served as vice president, secretary and treasurer of the Central West Virginia Medical Society, and was a member of the American Medical Association and the State Medical Association. He is survived by his wife, Mrs. Blair (Thompson) Carson, a son, Jack, and a daughter, Helen Blair.

Lt. Comdr. E. Lyle Gage (MC), USNR, of Bluefield, writes from Sicily that, even though the war has moved on into Italy, there is still plenty of work at his hospital. He expresses concern about the Wagner-Murray bill, which he labels "the Wagner-Murray-Dingle-Dangle bill," and says that the doctors in the service are hoping that those who remain at home will be able to "hold the line" and prevent the establishment of a Hitlerian bureaucratic dictatorship for medicine in the United States.

* * * *

Major A. C. Chandler, of Charleston, writes from India that the doctors in that area have plenty of work to do, with wonderful opportunities for experience and seasoning. "We are encouraged by the news from the European Theater of Operations," he writes, "and await anxiously for the real invasion. Once it is over in Europe, we in this area look for telling moves against the Japs."

* * * *

Captain William L. Claiborne, of Huntington, who has recently been attached to the 135th General Hospital at Fort Benning, Georgia, is now assigned to the Army Medical School, Army Medical Center, Washington, D. C.

* * * *

Major Spencer L. Bivens, of Charleston, reports from England that he has attended several meetings of the A. M. A. in the European Theater of Operations, as well as meetings of the Royal Medical Society in London. These meetings were formerly held once a month, but are now being scheduled in sections due to the increase in attendance.

"A few days ago," he writes, "I heard Lt. Col. Schullinger, chief of the surgical service at a general hospital, speak on the subject of penicillin. He possibly has had more experience in the use of penicillin than any other American physician overseas. He not only spoke of the value of the drug when indicated, but stressed the fact that it should not be used in case of a penicillin resistant organism."

At this same meeting, there was a discussion of the "occlusive dressing" in the treatment of certain dermatologic conditions. "Four per cent crude coal tar is used with a pressure bandage," he says. "The dressing is left in place for from four to six days. This gives the condition a chance to heal and discourages over-treatment."

Major Bivens, who has been stationed in England for several months, says that he has recently seen Major Claude B. Smith and Lt. Col. Bert Bradford, of Charleston, and that he has heard from another Charlestonian, Lieutenant T. P. Mantz, who is stationed somewhere in the British Isles.

MARINE RIBBING

I think in the use of preserved cartilage, particularly in the service, you do occasionally have to be careful. I was putting a preserved bridge in a boy one morning and he got quite inquisitive about it, and by the time I got through he said, "Doctor, where did you get the cartilage?" I said, "It came from a rib." He said, "I know, but what ribs did you get it from? What kind of ribs?" "Oh," I said, "You don't need to get hot and bothered about it, it isn't going to bother you. You are just using a piece of another sailor's rib." "My God, doctor," he said, "If you had only said anything but that. I'm a Marine!"—Capt. H. L. D. Kirkham, Military Surgeons' Meeting, October 21, 1943 (reported in "*Digest of Treatment*").

CANCER OF THE BREAST

"Cancer is one of the most curable of diseases." To be curable, early diagnosis is essential, and prompt, proper, and adequate treatment is mandatory. Cancer is the most common cause of a definite lump in the breast of non-lactating women over 25 years of age. Each decade there is an increasing incidence of carcinoma of the breast in white civilized nulliparous women. Eleven per cent of all cancers occur in the breast, which is an external organ, and accessible to vision, palpation, and transillumination. One would expect a lump in the breast to be discovered early, investigated, receive treatment and be cured. Nevertheless the average woman of today who discovers a lump in her breast goes to her doctor only four weeks sooner than the women of the 1900's or about four to six months after discovering the lump. Consequently 50 per cent of carcinomas of the breast in large clinics already have axillary metastases.—Gregory E. Stanbro, M. D., in *The Journal of the Oklahoma State Medical Association.*

Every day one out of twenty people in the United States is too sick to attend school or work.—*Food and Nutrition News.*

Obituaries

JAY RANDOLPH CRAWLEY, M. D.

Dr. Jay Randolph Crawley, of Anjean, Greenbrier county, was born at Marion, Ohio, in 1891, son of the late John and Harriet (Randolph) Crawley. He received his degree of M. D. at the Ohio State College of Medicine, Columbus, in 1917, and was licensed to practice in West Virginia in 1921. He had been engaged in industrial practice at Anjean since 1927. He was a member of the Greenbrier Valley Medical Society, the West Virginia State Medical Association, and the American Medical Association.

Dr. Crawley died of heart disease in a hospital at Charleston, February 2, 1944, following an illness of several months. He is survived by his widow, Genevieve Crawley, and by four sisters, Mrs. G. H. Gelbrith, Chicago; Mrs. C. W. Katzel, Wheeling; Mrs. Lee Inskeep, Steubenville, Ohio; and, Mrs. Frank O'Brien, Manila, P. I.

CHARLES BENTON MARSHALL, M. D.

Dr. Charles Benton Marshall, 51, of Nitro, died of cerebral hemorrhage, February 5, 1944, at University Hospital, Baltimore.

Dr. Marshall was born at Sunlight, Greenbrier County, West Virginia. He received his education in the public schools, at the University of Virginia, and at University of Maryland School of Medicine, Baltimore, graduating from the latter institution with the degree of M. D., in 1920. He was licensed in West Virginia the same year. After serving for a short time in the USPHS, he located at Nitro, where he continued in practice until a few weeks prior to his death.

He was a Mason, and a member of St. Paul's Methodist church, at Nitro. He was an active member of Kanawha Medical Society, the West Virginia State Medical Association, and the American Medical Association. Surviving are his widow, Margaret (Beimiller) Marshall, and three sons, Charles B., Jr., a student at the University of Maryland School of Medicine; James Edward, a student at Staunton Military Academy; and, John Robert, at home.

BUY MORE BONDS
BUY WAR BONDS

County Society News

BOONE COUNTY

At the last regular meeting of the Boone County Medical Society, the following officers were elected for 1944: President, R. L. Hunter, Whitesville; vice president, D. F. Pauley, Jeffrey; and, secretary-treasurer, J. Paul Aliff, Nellis.

J. PAUL ALIFF, M. D.,
Secretary.

CABELL COUNTY

An interesting address was delivered by Dr. T. B. Washington, instructor in urology at the Medical College of Virginia, Richmond, at the regular monthly meeting of the Cabell County Medical Society, held at the Hotel Prichard, Huntington, February 10, at 8:30 P. M. His subject was "The Distribution of Pain in Lesions of the Upper Urinary Tract." The address was illustrated by lantern slides.

COLE D. GENGE, M. D.,
Secretary.

CENTRAL WEST VIRGINIA

An interesting paper on the use of sulfa drugs was presented by Dr. Fred R. Whittlesey, of Morgantown, before the Central West Virginia Medical Society at the regular dinner meeting held January 27 at the Presbyterian church, in Buckhannon. Several members participated in a roundtable discussion which followed Dr. Whittlesey's address.

The regular spring meeting of the society will be held at Gassaway late in April.

J. M. COFER, M. D.,
Secretary.

FAYETTE COUNTY

The annual banquet of the Fayette County Medical Society was held at the Glen Ferris Inn, Glen Ferris, January 25, 1944. Two interesting case histories were presented by Dr. J. B. Thompson, of Oak Hill.

At the business session which followed the scientific program, Dr. J. Marshall Carter, of Glen Ferris, was elected to membership. The following officers were elected for the ensuing year:

President, Claude Frazier, Winona; vice president, J. B. Thompson, Oak Hill; secretary-

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treasurer, Eugene S. Carter, Jr., Boomer; delegates, W. E. Bundy, Minden and J. Marshall Carter, Glen Ferris; and, alternates, Claude Frazier and J. B. Thompson.

EUGENE S. CARTER, JR., M. D., *Secretary.*

KANAWHA MEDICAL SOCIETY

D. A. R. Hollender, of Chicago, head of the Department of Otolaryngology of the University of Illinois, was the guest speaker at the regular monthly meeting of Kanawha Medical Society, held February 8, 1944, at the Daniel Boone Hotel, Charleston. His subject was, "The Treatment of Upper Respiratory Infections." The paper was discussed by Drs. V. L. Lance and V. E. Holcombe.

Preceding Dr. Hollender's address, Dr. J. E. Cannaday presented a paper on "The Uses of Cutis Graft in Surgery." The discussants were Drs. J. Bankhead Banks, R. L. Anderson, and R. K. Buford.

Dr. Tracy N. Spencer, Jr., of South Charleston, was elected to membership in the society.

By a vote of 19 to 10, the society went on record as approving the medical-surgical plan now being operated in Kanawha county by Medical Service, Inc.

W. PAUL ELKIN, M. D., *Secretary.*

LOGAN COUNTY

Dr. William C. Stewart, of Charleston, president of the Kanawha Medical Society, was the guest speaker at the regular monthly meeting of the Logan County Medical Society, held at the Aracoma Hotel, Logan, February 9, at 8 P. M. His subject was "Pneumonia."

The Medical Film Guild's sound movie, "Inguinal Hernioplasty," in technicolor, was shown before the society at a meeting held in Logan, January 17. The film was shown in connection with the demonstration by representatives of the Singer Sewing Machine Company of an ingenious suturing instrument.

T. H. MILLMAN, M. D., *Secretary.*

MERCER COUNTY

Dr. Hampton St. Clair, of Bluefield, was the guest speaker at the regular monthly meeting of the Mercer County Medical Society, held at the Hotel West Virginian, Bluefield, January 20, at

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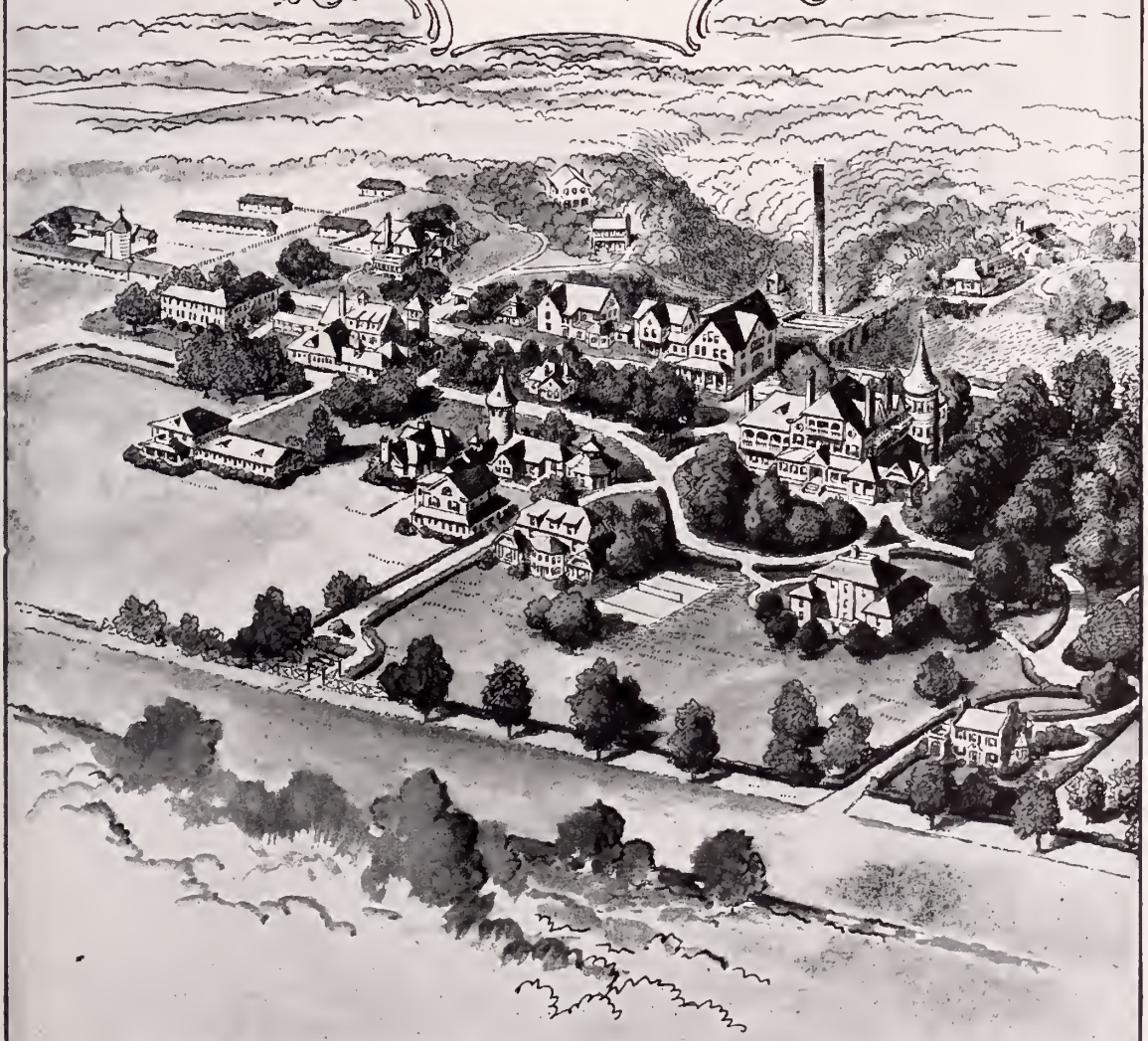

LITERATURE ON REQUEST

8:30 P. M. His subject was "Recent Developments in the Treatment of Burns." The paper was discussed by several members of the society.

Case reports on unusual dislocations and obstetrics were presented, respectively, by Dr. Frank J. Holroyd and Dr. Harry G. Steele.

Dr. Frank M. Huff, president, announced the appointment of the following as members of the program committee for 1944: Drs. Ben W. Bird, Jr., Princeton, and J. R. Shanklin and Hampton St. Clair, Bluefield.

FRANK J. HOLROYD, M. D.,
Secretary.

OHIO COUNTY

Dr. John B. McMurray, of Washington, Pa., was the guest speaker at the regular monthly meeting of the Ohio County Medical Society, which was held in the solarium at the Ohio Valley General Hospital, Wheeling, February 18, at 9 P. M. His subject was "Vertigo." The paper was discussed by Drs. R. A. Tomassene, A. L. Jones, E. L. Jones and M. B. Williams.

ROBT. W. W. PHILLIPS, M. D.,
Secretary.

Woman's Auxiliary

CABELL COUNTY

Dr. Ray M. Bobbitt, of Huntington, was the guest speaker at a luncheon meeting of the Woman's Auxiliary to the Cabell County Medical Society, held at the Frederick Hotel, Monday, February 14, with Mrs. R. Stuart Van Metre, president, presiding. He discussed the provisions of the Wagner-Murray bill as the same would affect members of the medical profession and employers and employees, and spoke briefly on the subject of medical-surgical plans now being studied by medical societies in West Virginia.

At a business meeting which followed Dr. Bobbitt's address, the Auxiliary endorsed the proposed plan for a full-time city-county health unit. The president was authorized to represent the Auxiliary at the next meeting of the city-county health committee.

MRS. C. H. PLYMALE,
Secretary.

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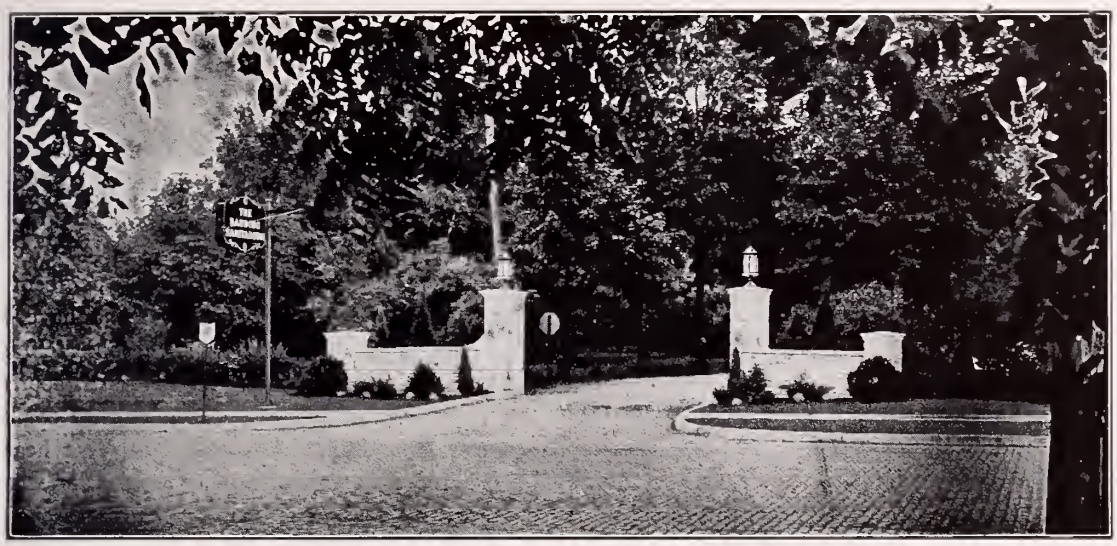

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LEWIS COUNTY

A meeting of the Woman's Auxiliary to the Lewis County Medical Society was held November 18, 1943, at the home of Mrs. Ralph M. Fisher, at Weston.

The part to be played by the Auxiliary in the fight against the Wagner-Murray bill (S. 1161) was discussed at length by the members. The discussion was led by the president, Mrs. Fisher. Communications from state officers were presented by Mrs. S. H. Burton and Mrs. Harvey M. Andrews.

MRS. A. E. LONG,
Secretary.

30,000,000 TB CASES IN FREE CHINA

In Free China ten per cent of the population, or 30 million persons out of a population of 300 million, are infected with tuberculosis, according to the statistical department of the National Health Administration.

Even in prewar China, Dr. Szeming Sze, editor of the *Chinese Medical Journal*, estimates that eight per cent of the population of all China suffered from tuberculosis, in his revised edition of *China's Health Problems.—Bulletin of the National TB Assn.*

THE SCIENCE OF HEALTH

Under this nomenclature Meredith discusses the health of people in general. He points out that about 10 per cent of the population may be considered as being sick; one-half of these seriously ill. Ten per cent of the population may be classified as "well", while the large intermediate group at the best can only be considered as being "semi-well."

Stated somewhat differently, Ryerson would classify this intermediate group of 90 per cent as follows: 30 per cent of these individuals have loss of health; 30 per cent have poor health; 20 per cent have average health. In other words, approximately only 30 per cent of the people in the country may be said to enjoy average to excellent health. These figures are confirmed in part by the examination of the draftees of this country. Approximately 50 per cent of the first two million registrants who were examined, according to the earlier figures released, were found unqualified for general military service. However, 10 per cent of these were disqualified for lack of educational qualifications. * * *

The large number of men who physically and psychically are deemed unable to cope with the exigencies of military life should make American people pause and think. Physicians should be stimu-

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lated to greater efforts in the field of personal preventive medicine in order to build up and strengthen the large group of people who are considered as "semi-well" and who have poor health to a bodily state in which they should be able to lead a healthy and happy existence. * * *—*New Orleans Medical and Surgical Journal.*

NO PROPHYLAXIS FOR MALARIA

Malaria cannot be cured by any known means. Patients may be eased over into a state of latency, *i.e.*, malaria without symptoms, but subject to the possibility, or even likelihood, of relapse whenever the resistance of the host is so reduced as to allow a recurrence of the active phase of the disease. Antimalarial drugs must be considered as suppressive rather than curative. Furthermore, there is no effective prophylaxis other than avoidance of infective mosquitoes. Drugs used "prophylactically" may prevent acute manifestations, but they do not assure against latency. The implications, therefore, are obvious.—*Wisconsin Medical Journal.*

DECLINE IN TB DEATH RATE

The 1942 tuberculosis death rate per 100,000 population in the United States was 43.1, according to official figures just issued by the U. S. Bureau of the Census. Since the 1941 death rate was 44.5, the final figure for 1942 represents a decline of three per cent in one year. In view of the fact that 1942 was the first year of America's participation in the war, this continued decline constitutes a distinct achievement.—*Bulletin of the National TB Assn.*

SYPHILIS AND SELECTIVE SERVICE

Over 284,000 cases of syphilis have been found as the result of the examinations thus far performed on registrants of the first, second, and third registrations. Of these 93,000 were among white, and 191,000 among Negro registrants. Of a total of 71,000 cases of gonorrhea, 34,000 were among white, and 37,000 among Negro registrants.—Col. Richard H. Eanes, MC, in *Venereal Disease Information.*

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OLIVER WENDELL HOLMES, M. D.

Oliver Wendell Holmes is known to the world as a poet, essayist and philosopher. Yet he received his medical degree from Harvard University in 1836 and practiced until 1857 at which time his "Autocrat of the Breakfast Table" began to be published in the Atlantic Monthly. Holmes was by no means Boston's most famous doctor, but he was certainly the most famous Bostonian who ever practiced medicine. — *Bulletin of the Woman's Auxiliary to the A. M. A.*

PSYCHOGENIC RHEUMATISM

Two Army Medical Corps physicians have given the term "psychogenic rheumatism" to the symptoms of arthritis or rheumatism caused by mental and emotional disturbances, basing their findings on studies of 450 patients. In a special study of fifty of these men, x-ray and other tests showed no joint or muscle involvements to account for the pain. However, most of the same men did have definite signs of emotional and mental conflict and even gave histories of nightmares, temper tantrums, sleepwalking, and other behavior problems. The physicians believe that such patients need psychotherapy to aid in recovery.—R. N.

WOMAN'S NATURE UNCHANGED

It is often stated that there has been a fundamental change in the nature of women especially during the postwar period. According to Charles Duff, there has been no fundamental change in the nature of woman since the dawn of history; there is a peculiar sameness about woman's nature everywhere and at all times. The specific reason for this is that she has a function which dominates all others and far exceeds in their impelling force all those of man—the function of procreation and the early care of children. After self-nourishment, it is the supreme function of the human being, and very well woman knows it. Her physical and psychological texture is patterned toward this great end. Her whole behavior revolves around it and is held in a more or less fixed manner. The superficial fashions and manners of woman may change; but not woman herself. — Joseph Baer, M. D., in *The Journal of Southern Medicine and Surgery.*

MEDICAL PRESCIENCE

Let it be a matter of record that doctors who fear socialized medicine in any form are not selfishly reminiscent, but, as Walter Pater once said, "prescient of the future." Let the politician who

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would force the issue look upon the record and be prepared for the consequences.

The far-seeing doctors do not claim omniscience, but experience has taught them that those who bow to bureaucracy and spend valuable time filling blanks in triplicate do not climb mountains, ford streams and brave storms to save the sick. Let doctors remember that it requires more fortitude to maintain freedom than to accept tyranny.

As a profession, we are at war, fighting for the one and only freedom worth having—the freedom to oppose everything that robs us of individuality in our service to humanity.

We know that medicine is a vital living science with evolutionary ends and that it should not be "rough hewn" by revolutionary trends.—*Journal of the Oklahoma State Medical Association.*

FOX HOLES OF THOUGHT

There is a type of physician who digs himself into a foxhole of thought and persistently snipes at all suggested improvements to the present system of distributing medical care.

He is most likely to confuse the problems in distribution of medical care with the vicious probabilities in misbranded "social security" schemes. He is thus neatly entrapped by a fast talking demagogue.

There are in addition, an utter few other doctors whose flippant suggestion to "let them have welfare' 'is only too reminiscent of a Bourbon philosophy.

We recall, to complete our perspective, that there are groups among bureaucrats who refuse to unbend, and are sometimes dishonest. Compulsion and capricious rulings are their stock in trade. They can ostensibly aim at an improved economy, yet sabotage the common man, to their own devious ends.

The bright side of the picture shows that the majority of doctors as well as elective officials are honest and serious. They well know that our changing national developments will inevitably require

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PATULIN AND THE COMMON COLD

Not related to penicillin, but also a mold-derived drug, patulin is receiving tests in Britain for its effect on the common cold. A recent report in *The Lancet* shows that the new drug completley cured 57 per cent of a group of men in 48 hours, while only 9.4 per cent of those not treated recovered in that time. Inhalant of patulin seemed to control infections of the nose and throat in record time.—R. N.

PERMANENT DUTY FOR TB WORKERS

While we look for the virtual conquest of tuberculosis within the measurable future, we cannot hope for the annihilation of the tubercle bacillus. Unless nature takes an unexpected whim to do away with it beforehand, this acid-fast rod may be present at the obsequies of the last man on earth. Therefore, it is well for tuberculosis workers to prepare for permanent duty during war and peace, in good times and bad, lest the microscopic vegetable seize the unsuspecting moment and the fertile spot to seed itself anew.—J. Burns Amberson, M. D.

HOW TO GIVE COD LIVER OIL

Some authorities recommend that cod liver oil be given in the morning and at bedtime when the stomach is empty, while others prefer to give it after meals in order not to retard gastric secretion. If the mother will place the very young baby on her lap and hold the child's mouth open by gently pressing the cheeks together between her thumb and fingers while she administers the oil, all of it will be taken. The infant soon becomes accustomed to taking the oil without having its mouth held open.

If given cold, cod liver oil has little taste, for the cold tends to paralyze momentarily the gustatory nerves. As any "taste" is largely a metallic one from the silver or silverplated spoon (particularly if the plating is worn), a glass spoon has an advantage.

On account of its higher potency in vitamins A and D, Mead's cod liver oil fortified with percomorph liver oil may be given in about one-fourth the dosage of ordinary cod liver oil, and is particularly desirable in cases of fat intolerance.

REFRESHER COURSE IN OTOLARYNGOLOGY

The Department of Otolaryngology of the University of Illinois College of Medicine has announced its spring refresher course, to be held at the college, in Chicago, March 20-25, 1944. The course will be largely didactic, but some clinical demonstrations have been included. The fee is $50. In letter requesting application, state school and year of graduation and also give details concerning specialty training and experience. Address Department of Otolaryngology, University of Illinois College of Medicine, 1853 W. Polk St., Chicago.

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PATHOLOGY OF THE INTERVERTEBRAL DISC*

By WALTER G. J. PUTSCHAR, M. D.
Charleston, West Virginia

For a long time the attention of anatomists, pathologists and clinicians studying the spine was mainly focused on the vertebrae rather than on the intervertebral discs. Only within the last twenty years has a more detailed knowledge of the finer structure and the pathology of the disc been acquired. And only then the great physiological and clinical importance of this essential element of the vertebral column has been appreciated. In order to arrive at a proper understanding of the pathology of the disc and its clinical significance it is necessary to point out certain facts of its embryonic development, its structure and function in the human and in the animal.

The earliest axial skeletal structure in the embryo is the stringlike, unsegmented notochord consisting of a solid mass of large vesicular cells. Around the notochord the anlage of the segmental vertebrae begins to form as precartilaginous and later cartilaginous tissue. At this time a horizontal zone in the middle of each vertebral segment becomes clearly defined as the first anlage of the intervertebral disc. This area does not change to hyalin cartilage as the anlage of the vertebra does. The notochord, which changes into a narrow channel inside of the vertebral segment shows a nodular swelling in the disc segment occupying the center of the later disc. (Fig. 1A). Soon after the ossification of the vertebra begins the intra-

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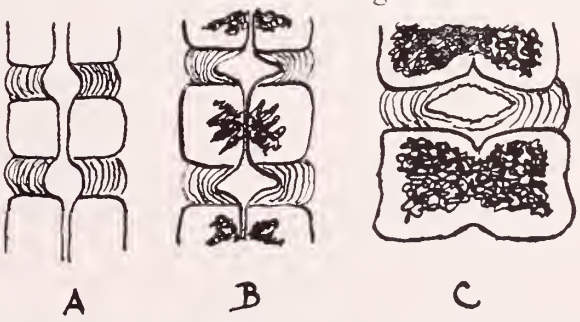

Fig. 1.—Embryonic development of discs and vertebrae. (A) Nodular swelling of notochord in disc area. (B) Beginning disappearance of intravertebral portion of notochord after onset of ossification. (C) Beginning formation of nucleus pulposus from notochord remnants and disc material, funnel-shaped depression of vertebra at former site of notochord.

*Presented before the Cabell County Medical Society, Huntington, October 14, 1943.

vertebral portion of the notochord disappears (Fig. 1B) but the place where the notochord enters the disc segment remains permanently the weakest spot in the end-plate separating the disc from the vertebra. (Fig. 1C). In this area herniations of disc material into the vertebrae frequently develop in later life.

The fully developed disc is a highly specialized structure anatomically and functionally. It gives the spinal column flexibility, elasticity and a considerable amount of rotary freedom. The total height of the discs amounts to about one-third of the total height of the vertebral column. The individual disc is a biconvex structure consisting of a rather firm fibrocartilaginous ring in the periphery (annulus fibrosus) and a semiliquid jellylike center (nucleus pulposus) enclosed between the sturdy end-plates of hyalin cartilage which separate the disc from the two adjacent vertebrae. (Fig. 2B). The annulus

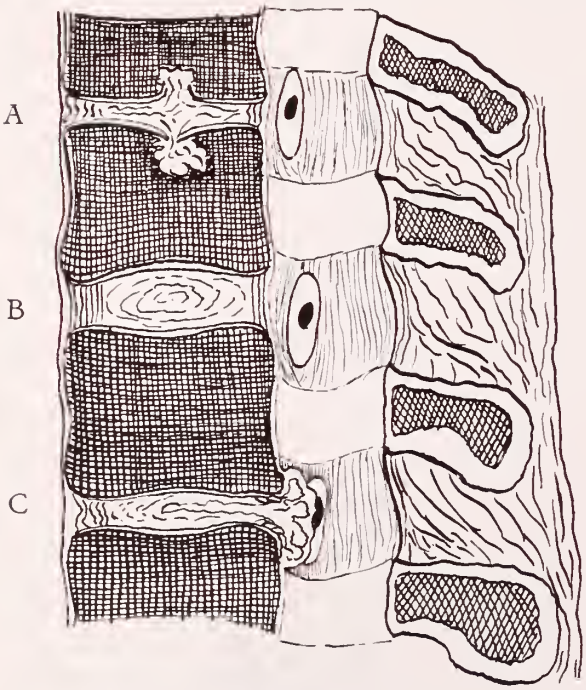

Fig. 2.—Median section of lumbar spine without contents of spinal canal. (a) Narrowed disc with symmetrical intravertebral herniations at weakest point. (b) Normal disc. (c) Posterior herniation of disc compressing spinal root in foramen.

fibrosus is made of layers of tough fibers which alternate in a diagonal direction in order to permit some rotary freedom which is not very large on the single disc but permits considerable excursions due to the great number of segments in the whole spine. This tough ring is not equally well developed all around the circumference of the disc, but is strongest in front and rather weak in the posterior portion facing the spinal canal. This explains the frequency of disc herniations into the spinal canal. The nucleus pulposus consists of softened fibrous cartilage intermingled with remnants of the notochord embedded in rather moist jellylike matrix. Functionally the normal disc acts as a shock absorber of considerable flexibility and great efficiency. The whole disc is firmly fused with the adacent vertebrae and the structure is anteriorly and laterally reinforced by the strong anterior longitudinal ligament of the spine, while the posterior longitudinal ligament covering the portion of the disc facing the spinal canal is much weaker and narrower, again pointing out the structural weakness of the posterior circumference of the disc.

UPRIGHT GAIT

The pecularity of the function and of the pathology of the disc in the human is brought about by the upright gait. In the quadruped animal the spine is an elastic bridge which connects the front and hind legs but does not participate in the weight-bearing function which is entirely left to the extremities. In addition to this, any impact of the force of gravity hits the spine in the plane of the discs and is not pressing down on them. In the human due to upright position the spine is changed from an elastic horizontal bridge into a vertical weight-bearing column in which now the force of gravity is constantly pressing down on the discs. The change to the upright gait is phylogenetically a fairly recent development and there are no essential structural changes between the spine of animal and man which would compensate for the entirely different static and dynamic needs of the human spine. It is essential to understand these facts clearly in order to appreciate the particular vulnerability of the human spine in general and especially of the

disc which is weighted down, not only with the weight of head, neck, arms and trunk, but in addition by any burden that we lift or carry with our arms or our back. This explains why pathological changes of the discs are most commonly seen in the lumbar spine which bears most of the load and in the cervical spine which has the greatest freedom of motion, while the dorsal spine is better protected by the rigidity of the thoracic cage. Only due to the fact that all constructions of nature are calculated with a wide margin of safety can the human spine hold up under functional strain and stress of life and work as well as it does.

In the process of ageing certain changes take place in the disc. The nucleus loses part of its water content which causes some loss of elasticity of the gait, as noticed with increasing age. In the process of ageing and dehydration the disc loses height which explains the loss of height in old individuals. In some instances after loss of elasticity the disc is replaced by fibrous tissue. Blood vessels grow into the formerly avascular disc and partial or complete bony fusion of the adjacent vertebrae may occur, thus substituting the stability of bony union for the elasticity already lost and for the limited freedom of motion. This tendency to replace a useless or insecure disc with a more secure bony union is observed in any type of disc pathology, thus eliminating a weak link in the chain of the spinal column.

In discussing the pathology of the disc only those conditions which are characteristic for this structure shall be considered:

1. Herniations of disc.
2. Spondylolisthesis.
3. Kyphoscoliosis.
4. Senile kyphosis.

HERNIATIONS OF DISC

Herniations of the disc are most frequently observed and are clinically the most important form of disc pathology. Herniations may occur at any part of the disc; however, there are certain places of predilection. The herniations of the disc can be divided in anterolateral and posterior herniations and in internal herniations protruding into the marrow of the adjacent vertebrae. The rarest type of herniation is the anterolateral because in this area the fibrous ring is very strong and the anterior longitudinal ligament also helps to prevent herniation. This type of lesion is found only incidentally at autopsy and has no clinical significance since there is enough space to avoid pressure symptoms by a small herniation.

POSTERIOR HERNIATION

The most important lesion clinically is the posterior herniation into the spinal canal. In this case, due to the limited space in the spinal canal, even small protrusions may cause severe pressure on the spinal cord itself, on the cauda equina, or most commonly on single roots in the intervertebral foramen, depending on the localization of the lesion. The neurological and neurosurgical details of this condition are discussed by Dr. A. A. Wilson in this issue. Under influence of wear and tear or sometimes due to a sudden jolting impact or due to heavy strain in lifting, the weak posterior fibers of the annulus fibrosus may give way. Now either slowly or suddenly parts of the semiliquid material of the nucleus may escape through the defect in the ring. These herniations are most common in the lumbar portion, especially on the disc between the fourth and fifth lumbar vertebrae or between the fifth lumbar and first sacral segment. Second in frequency is the cervical spine, while the dorsal spine is less frequently affected. In the cervical or dorsal spine disc protrusions may give the symptoms of an extramedullary tumor. Most commonly, however, especially in the lumbar spine the lesion produces typical root pain. The reason for this is that most posterior protrusions develop not in the midline where the posterior longitudinal ligament reinforces the disc but more lateral at the weakest point. These lateral protrusions are in the immediate vicinity of the intervertebral foramen and easily exert pressure on the spinal nerve root in this foramen. (Fig. 2C). These lesions are

mostly singular; however, the possibility of protrusions at several discs should be considered if the pain refers to more than one root. Anatomically the lesion presents itself entirely extradural and consists of a prominence covered by a thin capsule. This capsule is formed by fibers of the posterior longitudinal ligament and remnants of the annulus fibrosus. The contents mostly consist of loose fragments and shreds of softened cartilage and jellylike debris. (Fig. 3). Sometimes

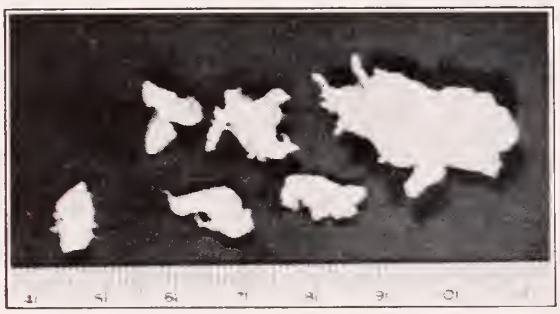

Fig. 3.—Surgical specimen from posterior herniation of disc (ruling in cm.).

part of the contents are still anchored in the disc. It is possible that at times a protruded disc may slip back into place and such occurrences may account for intermittent attacks of pain with symptom-free intervals. If the protrusion has been present for a long time some bony lipping at the margin may be observed. The lesion is usually demonstrable by x-ray, after introduction of contrast media into the spinal canal, as a constant filling defect at the level of the disc. Only when the herniation is so far lateral that it is entirely hidden in the intervertebral foramen and does not produce a filling defect on the dural sac it escapes demonstration by x-ray. If a large amount of the nucleus pulposus is extruded, a narrowing of the intervertebral space, which the affected disc occupies, may be observed. Before recognition of the finer anatomy and typical pathology of the disc such lesions have been occasionally operated upon and described but they were mistaken for true tumors (chondromas, myxomas or fibromas). Most cases, however, were considered as sciatica and the underlying pathology was not recognized.

The intravertebral herniations are the most common of all but they do not achieve as much clinical importance as those described above. Systematic postmortem examinations of the spine have shown that most individuals after the age of forty show some small disc protrusion into vertebral bodies. Only if the changes are very extensive will they cause backache and may show on x-ray. In some of these cases only the narrowing of the affected disc is noticeable while in extreme cases the protruded portion of the disc may be visible on x-ray as a nodular defect in the vertebral body. Multiple lesions of this type are supposed to be responsible for juvenile kyphosis. Compressing trauma of the spine, with or without fracture, may produce such lesions. However, the smaller ones which are only demonstrated at autopsy undoubtedly develop in most cases without any single traumatic incident, but rather due to the normal wear and tear of life and work. In these cases the cartilaginous end-plates which separate the disc from the vertebral body develop fissures or perforations, most com-

Fig. 4.—Degenerated disc with ruptured endplate and massive intravertebral herniation of cartilage (low power microphotograph).

monly at the weak spot in the center where the notochord joined the disc. (Fig. 2A). Subsequently under the stress and strain of gravity and motion some of the soft material of the nucleus pulposus may be forced into the marrow spaces of the vertebra.. (Fig. 4). Frequently this goes along with local hemorrhages, fibrosis of the surrounding bone marrow and formation of partly cartilaginous,

partly bony callus, to repair the local defect. (Fig. 5). Sometimes the expelled disc material is resorbed and only a small cyst remains in its place. If the bony sclerosis around the lesion is very marked it may make even a smaller herniation noticeable on x-ray. The main clinical significance of this type of lesion, I believe, is that it indicates telling

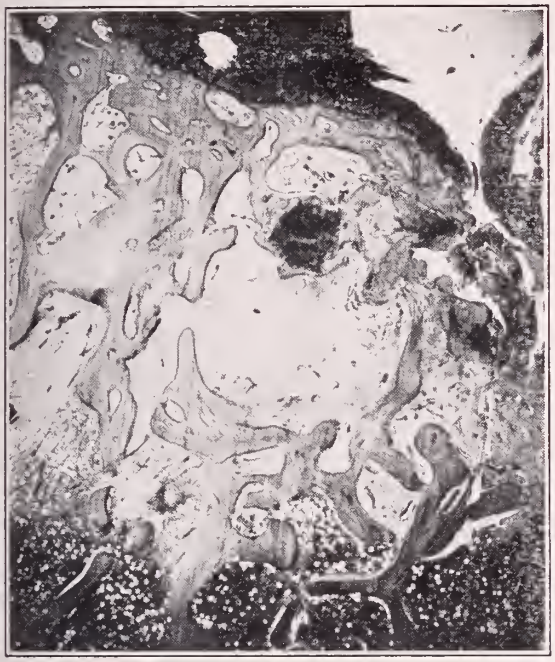

Fig. 5.—Intravertebral herniation with reactive fibrosis and osteosclerosis (low power microphotograph).

results of wear and tear on the spine. Discs with such ruptured end-plates and intravertebral herniations are not equal to their normal function as shock absorbers. Subsequently minor additional damages of such a spine may produce damage which may seem out of proportion to the trauma. It also should be remembered that only the more severe lesions of this type can be demonstrated by x-ray.

SPONDYLOLISTHESIS

In this condition there is a break in the continuity of the neural arch between the upper and lower joint surface. This is usually due to faulty development so that the vertebra consists of two pieces which are only loosely united. Naturally a vertebra like this is not very firmly anchored in the column and may start to slip anteriorly, especially if a person with such a congenital anomaly is subject to heavy physical labor or trauma. We are here concerned only with changes of the disc in this condition. Under the influence of the forces which promote the slipping, the fibers of the annulus are slowly disrupted and the whole disc is gradually changed from a solid structure into a joint-like cavity. (Fig. 6). Only after disruption of the disc is considerable slipping of the insecurely anchored vertebra possible. Again for the same mechanical reasons, as discussed above, this condition is most frequently encountered in the lumbar spine. Most frequently it is the fifth lumbar slipping on the upper surface of the sacrum. In the process of slipping much of the dis-

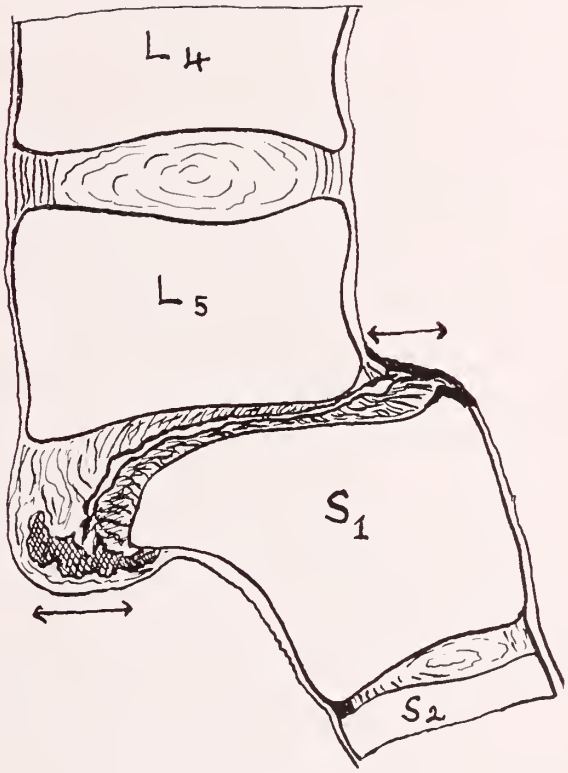

Fig. 6.—Median section of lumbosacral spondylolisthesis with jointlike transformation of disrupted disc and ossification of anterior prominence. (Drawing from section).

rupted disc material is squeezed out anteriorly. It is interesting to see that in an attempt to arrest the slipping, usually marked bony exostoses develop below the protruding vertebra and even ossification of parts of the protruding disc may occur. In some cases those adaptations suffice to arrest the condition pro-

vided that no undue demands are made on such a spine.

KYPHOSCOLIOSIS

Similar conditions may arise for some discs in severe degree of kyphoscoliosis, especially for those discs located at the vertex of a curve.

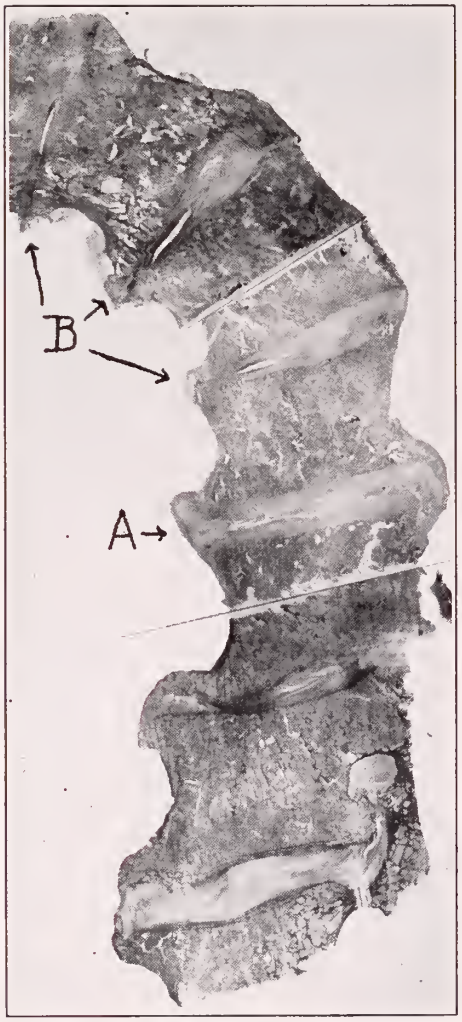

Fig. 7.—Dorsolumbar segment of scoliotic spine in frontal sections. (a) Disruption of disc. (b) Extreme compression of discs on concave side of deformity.

Due to the deviation from the midline the force of gravity produces a twisting strain which acts mainly on the disc. Actually one can see that those critically located discs become twisted and in time show partial or complete disruption. (Fig. 7A). Naturally the amount of slipping never equals the degree observed in spondylolisthesis since the vertebra even in the twisted scoliotic spine remains firmly anchored in the column. However, a moderate degree of rotary slipping may be observed in severe scoliosis. In a few cases of scoliosis with acute angle and joint-like transformation of the affected disc, the mechanical pull and pressure on the spinal cord may be sufficient to produce permanent damage with paresis or paralysis. Another influence of scoliosis on the disc is brought about by the shift of the line of gravity. In the normal spine the line of gravity falls in the midline of the vertebrae while in scoliosis it is shifted towards the concave side of the deformed portion. Subsequently the disc is under constant pressure in this area (Fig. 7B) which causes in time necrosis of this portion of the disc and may ultimately lead to bony fusion in this area.

SENILE KYPHOSIS

In senile kyphosis the normal curving of the dorsal spine is very markedly increased and becomes fixed. The line of gravity is now moved forward towards the anterior margin of the vertebrae. At this time the discs have lost much of their moisture and elasticity due to ageing. If now a constant pressure develops at the anterior margin due to the outlined

Fig. 8.—Senile kyphosis of dorsal spine with compression of anterior portion of discs and marked hypertrophic lipping of bone. (X-ray of specimen).

shift of gravitational impact, this portion of the disc is compressed and slowly destroyed. (Fig. 8). Finally hypertrophic bony lipping may overbridge the damaged disc or bony

fusion in this area may develop.

The material presented shows that the intervertebral disc is a highly specialized structure of great functional importance, but also a structure of considerable vulnerability. Most of its pathology is caused and all of it is influenced by mechanical strain and stress and the impact of gravity on the spine which is peculiar to the human and a consequence of the upright gait.

CLINICAL ASPECTS OF THE PROTRUDED INTERVERTEBRAL DISC

By ARCHER A. WILSON, A. B., M. D.
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During the past decade the surgical literature on this subject has become quite voluminous and from it has evolved a fairly clear cut clinical syndrome of low back and sciatic pain, due to compression of a nerve root by the protruded intervertebral disc. These discs had been found from time to time by many neurosurgeons and were usually called "chondromas" but their true nature and significance was unknown until the work of Mixter and Barr in 1934 emphasized that this lesion was the common cause of severe sciatic pain. While formerly "sciatica" was not considered as a surgical disease, most cases of low back and sciatic pain are now known to be due to root compression and are amenable to relief through surgery. Operation for the removal of protruded intervertebral discs is the most frequently performed in neurosurgical clinics today.

It is important that the patient describe in detail the characteristics of his backache, its location and radiation, if any, and whether or not such acts as coughing, sneezing or straining at stool causes an aggravation or radiation of pain and if so, where the pain is felt. Backache without radiation of pain to either hip or leg is seldom caused by a protruded intervertebral disc. It is important also to estimate the patient's tolerance for pain, whether the individual is neurotic and exaggerating a vague pain or gives an accurate description of the intractable pain which characterizes a root compression. The pain is usually incapacitating and intermittent over a period of time, the acute exacerbations occcurring after some lifting or straining action. Another outstanding characteristic of the pain of a protruded disc is its mechanical nature. Certain movements cause excruciating pain, often sitting in comfort is quite impossible, bending is difficult and painful, and only certain positions in bed enable one to rest in comparative comfort. The gait is often modified by spasm of the back muscles and listing to one side. In addition to the pain, there are often sensory disturbances which may be described with such a degree of accuracy on the part of the patient that the root involved may be determined at once. The sensations described may be as of electric shocks, burning, tingling, pricking or numbness and it is important to ascertain whether such sensations involve the great toe area or outer aspect of the ankle, since most of the lumbar protrusions involve either the great toe or little toe area of the foot.

There is usually a history of injury which was regarded as of no great consequence at the time. Lifting when bent forward appears

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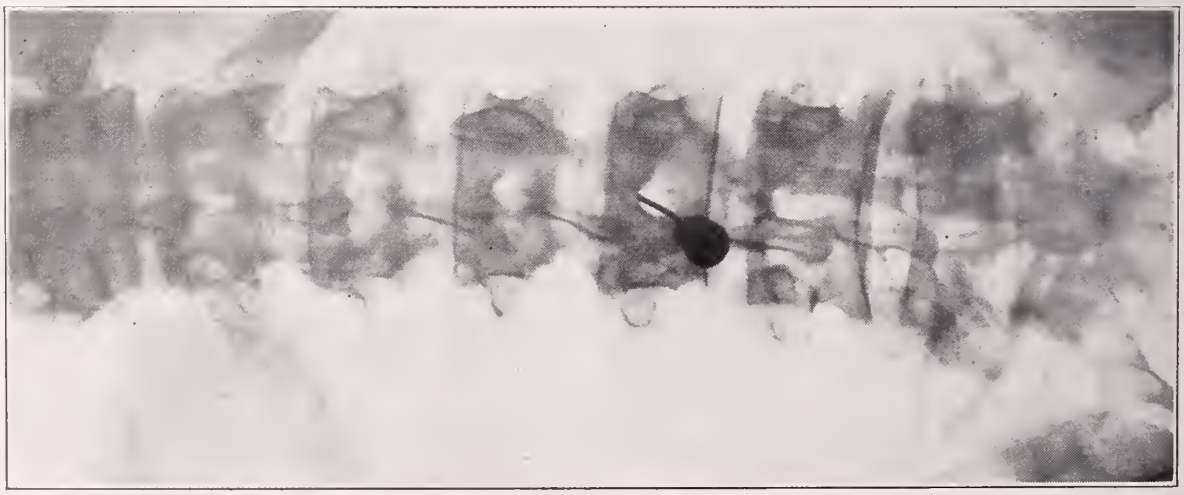
to initiate the pain most often, a "snap" being felt in the back rendering it difficult to straighten up for a while. Slipping without falling or a sudden misstep may produce the first pain. It it interesting to note the extreme rarity of such protrusions in association with fractures of the back.

There is usually an appreciable interval between the low back pain and the onset of the "sciatica" which may be days, weeks or months following the onset of the low back pain. This is thought to be due to stimulation of the sensory nerve endings in the posterior longitudinal ligament and the posterior annulus fibrosus and when the nucleus pulposus protrudes through the tear in the annulus and the intraspinal mass then impinges on the nerve root, the pain becomes of a sciatic distribution and from then on is aggravated by coughing, sneezing, etc.

This is very clearly illustrated by the following case history:

Mrs. M., age 24, was first seen in the Kanawha Valley Hospital, March 9, 1940 at the request of of Doctor R. L. Anderson. She stated that she had been in excellent health prior to 2 months ago when she jumped off a 5 foot wall, landing stiff legged on a concrete pavement. She had immediately a severe low back pain which incapacitated her and kept her in bed. Two weeks before admission (6 weeks after injury), the pain radiated to the left hip, thigh and down the back of the leg to foot and for the first time coughing, sneezing and straining at stool caused an acute exacerbation of the leg pain. She complained of numbness of the great toe area of the foot. Upon examination, there was weakness of the anterior tibial group of muscles, positive Kernig and Lasegue tests, hypoesthesia of the 5th lumbar dermatome (great toe area of foot) and tenderness lateral to the fourth lumbar spinous process. A lipiodol injection showed a left anterior filling defect in the column of oil between the 4th and 5th lumbar bodies. On operation, a large disc extruded itself in two pieces upon its exposure.

The overwhelming majority of protrusions are found between the 4th and 5th lumbar bodies (involving the 5th lumbar root) or at the lumbosacral joint (involving the 1st or 2nd sacral roots). The sensory disturbance in the former are roughly in the great toe area while in the latter, in the outer aspect of the foot, and associated with a diminished or absent ankle jerk. Discs involving the 3rd, 4th or 5th lumbar roots as a rule do not alter the ankle jerk. Of course, the protruded disc may be anywhere along the vertebral column. When they occur in the cervical or dorsal areas, they produce characteristic root pains which are aggravated by coughing, sneezing, etc., and distributed to the periphery of the involved root, and in addition, are associated with evidence also of cord compression. Protruded discs in the upper lumbar area produce a different radiation of pain, usually to the front of the thigh and alter the knee jerk. One should be forewarned therefore, when



Showing almost complete removal of lipiodol after fluoroscopic and x-ray study. Needle in third lumbar interspace, only a few droplets of lipiodol remain below head of needle.

the pain does not follow the posterior thigh. Since the ruptures occur in the posterolateral areas usually, the pain is therefore confined to the side involved. Occasionally, the rupture and consequent protrusion of the disc occurs through the posterior longitudinal ligament in the midline in which case one might suspect a bilateral radiation of pain down the backs of the legs.

Except in women, the examination of patients who complain of low back pain should be conducted with all clothing removed. One can then observe the gait and posture, as the care with which these patients move to avoid pain during the examination is striking. Many will show a flattening of

Large midline protruded disc in 2nd lumbar interspace, causing complete obstruction to Lipiodol (table tilted with head sharply down, needle in third lumbar interspace).

the lumbar curve and evidence of spasm of the erector spinae muscles. There is often a scoliosis or listing which is usually away from the painful side and forcible bending toward the side for a minute will sometimes intensify the back pain and may reproduce the whole pattern of leg pain, including the sensory disturbance. Forward bending is painful and limited and lateral manipulation and palpation of the 4th and 5th lumbar spinous processes is painful, depending upon and denoting which root is compressed. Percussion over these spinous processes will often show the root involved and deep pressure or percussion lateral to the spinous process will produce pain locally as well as reproduce the original pain complained of and in its distribution so that, by careful examination of the back, the exact root may be identified. Palpation, along

Protruded disc between fourth and fifth lumbar bodies. Needle in third interspace.

the course of the sciatic nerve involved usually reveals varying degrees of tenderness. This should always be carefully done to rule out a primary neoplasm of the nerve itself.

Perhaps the most constant finding is the positive Kernig and Lasegue tests. With the thigh flexed on the abdomen, the leg is extended until pain is complained of, if then the ankle is forcibly dorsiflexed, the pain is greatly aggravated because of the stretching of the sciatic nerve.

The sensory examination will yield helpful results only if the tests are carefully carried out with an appreciation of the anat-

omical distribution of the 5th lumbar and 1st sacral segments, as outlined above. The sensory changes can usually be demonstrated with a pin and piece of cotton. They may often be produced subjectively by forcibly flexing the neck on chest or by placing the sphygmomanometer cuff around the neck and producing a pressure of 40 mm. of mercury. This is the jugular compression test and when positive is pathognomonic of an intraspinal lesion.

The ankle jerk should be diminished or absent only if the 1st sacral root is involved in the compression.

As a rule, motor weakness is not complained of, unless there is some focal paralysis in the leg. Examination of muscle strength is difficult and uncertain because of the pain movement produces. Muscle cramps are complained of often, chiefly at night and are relieved by exercising or rubbing the member.

In summary, patients with lumbar protrusions of the intervertebral disc complain of severe persistent or intermittent low back and sciatic pain, aggravated by coughing, sneezing and straining at stool. There is often a traumatic history with the subsequent back pain preceding the onset of the sciatic pain. Stiff leg raising is painful and limited and Lasegue's test is positive.

SYMPTOMATOLOGY

1. Protrusions between the 4th and 5th lumbar bodies (5th lumbar root).
   (a) Tenderness to deep pressure and percussion lateral to the 4th lumbar spinous process which reproduces the original pain.
   (b) Positive jugular compression test results in tingling in the great toe area and there is a hypoesthesia in this area.
   (c) The knee and ankle jerks are not disturbed.
2. Protrusions at the lumbosacral joint (1st and 2nd sacral roots).
   (a) Tenderness to deep pressure and percussion lateral to the 5th lumbar spinous process, reproducing the original pain.
   (b) Positive jugular compression test results in tingling in the outer aspect of the foot or hypoesthesia in this area.
   (c) The ankle jerk is diminished or absent.

In the matter of differential diagnosis, a thorough x-ray study should be made of the lower dorsal, lumbar and sacral areas to rule out evidence of bone pathology, such as fractures, tuberculosis, low grade osteomyelitis, metastatic bone lesions, arthritis, spondylolisthesis and spina bifida occulta. If an operation is to be performed on the lumbar spine, for accurate orientation, one wishes to know whether there are six lumbar bodies or whether there is any anomaly between the usual landmark relation of the 4th lumbar spinous process and the crest of the ileum which not infrequently occurs.

Lesions of the prostate, rectum and pelvis must also be ruled out.

MYELOGRAPHY

The use of myelography has become a controversial question in recent years, though its use in the early years of the evolution of the "disc syndrome" was necessary, in spite of certain objections to its use. The substances used for this purpose are lipiodol, air, thorotrast and more recently an aqueous solution known as pantopaque. Air is the least objectionable because of its simplicity, and the fact that it leaves no x-ray or other evidence of its use. It has, however, the distinct disadvantage of being the most inaccurate, and it is pretty well agreed that a negative air myelography does not by any means, rule out a protruded disc. Thorotrast is chiefly objectionable because it must be removed and by a rather tedious spinal drainage. Lipiodol is objectionable because, if left in, it gives rise to a chemical arachnoiditis, regarded as harmless, but is only absorbed in a matter of years. Lipiodol gives rise to "false positives" and does not always show lesions which are present. The chief reason for the latter is that

the disc may be too far lateral to encroach upon the spinal canal and thus produce no defect in the column of oil. A negative lipiodol, therefore, should be no contraindication to operation if it is felt that the patient has a root pain. Since most discs are now removed extradurally one does not wish to open the dura to wash out an opaque media.

For some years, we have been using lipiodol almost routinely, injecting 2.5 cc's in the 3rd lumbar interspace and leaving the needle in place during the fluoroscopic and x-ray study and removing the lipiodol by gentle aspiration upon the conclusion of the study. This complete study can be done in some 20 to 30 minutes. In many instances the oil can be completely aspirated with very little discomfort to the patient. In other instances, the nerve roots create so much pain by contact with the needle point upon aspiration, that complete removal is difficult or impossible. Pantopaque gives equally as good pictures and is more easily aspirated because of its aqueous characteristics but is subject to the same difficulties sometimes as in aspirating the lipiodol.

The advantages of any type of myelography are that the lesion is definitely located so that the surgical approach may be direct and with the minimum disturbance and destruction of the tissues involved. Occasionally, multiple discs are present which will be shown by myelography.

Myelography will always be a useful and necessary diagnostic aid in a certain percentage of cases, but its use will decrease as the clinician through careful history and painstaking clinical examination, increases his diagnostic skill to the point where there can be little doubt as to the precise localization of the suspected protruded disc.

Improvement in the surgical handling of these lesions has kept pace with the improvement in the clinical diagnosis. Instead of a bilateral laminectomy as was formerly done and still is necessary sometimes in midline protrusions, discs can now be removed by an experienced operator with a small skin incision, separation of the muscles from the spinous processes and laminae of the adjacent bodies on one side with little or no bone removal, so that the hospitalization and recovery periods are greatly shortened and no appreciable damage has been done to the weight-bearing structures of the back.

One should not get the impression of too rosy a picture following operation for removal of a protruded disc, particularly in compensation cases or those whose injury is a matter of litigation. While the root pain in these cases is usually relieved, there are other complaints, often new ones, which tend to nullify the good results usually obtained in private practice and prevent a prompt recovery and return to industry. It is therefore, particularly desirable to evaluate preoperatively the personality make-up of the patient and determine whether or not certain neurotic tendencies are present which will make for a poor result from surgery. But if these cases are properly selected, properly diagnosed and properly operated upon, the result in the majority of cases is extremely good. Grateful appreciation is usually expressed by those who have been periodically disabled by virtue of a root pain caused by compression of a protruded intervertebral disc.

DEATH RATE FROM WOUNDS, 1861-1943

In 1861, in the Civil War, 40 out of every hundred men in the Union Army wounded in battle or stricken with disease died. In 1943, in the battle of Guadalcanal, the fever-ridden swamp of the South Pacific, the United States army death rate was only one per cent. Only one out of every hundred.

In World War I, if a wounded soldier were not given care within six hours, his chances of living were slight. Only six hours to live if you were wounded in battle—six hours before gangrene set in. Today, with sulfa drugs carried onto the battlefields not only by the Medical Corps, but by the soldiers themselves, with sulfathiazole pills to be taken the minute a wound is inflicted, and sulfa crystals to sprinkle into the wound, the period a soldier is safe from infection has been lengthened into days.—*Milwaukee Medical Times.*

VIRUS FOLLICLES: FOCI OF INFECTION IN INFLUENZA

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In the epidemic influenza cases occurring in such profusion during the past winter, one sign persistently and regularly seen was the presence of new follicles on the posterior pharyngeal wall. These follicles are differentiated from the frequently seen chronic granulations or follicles by the addition of two or three minute new arteries in the form of a V or Y. Also, these follicles are intensely red and angry looking during the first few days.

Occasionally the follicles suppurate and appear in various stages of pustular formation, but in the majority of cases, they are small, firm, discrete masses of granulation tissue varying in size from a small pea to a conglomerate mass a centimeter or more in diameter.

They vary in their elevation from the surrounding mucosa, some appearing conical in shape. In other cases, they appear as elevated masses of irregular shape and flattened, so that they are but slightly elevated above the surrounding tissue.

In one case, all the follicles had merged and were covered with a dried pustular scab so that the mucosa from the nasopharynx down to the laryngopharynx was one massive scab. The patient was unable to breathe through her nose and was extremely toxic, yet had no pain in her throat.

Many of these influenza victims have no symptoms referable to the throat at the time they are seen and must be queried at great length to elicit the fact that they did have a sore throat at the beginning of their present trouble. However, all complain of extreme weakness, weariness and lassitude.

In viewing a case wherein the follicle has suppurated and emptied itself, one can readily understand how and why the so-called "virus" or "atypical pneumonia" results. In no case of this atypical pneumonia examined have the pharyngeal follicles been absent.

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Even though a pustule does not form, absorption continues through the lymphatics as long as the follicle remains. The general improvement resulting from the obliteration of the follicles is truly remarkable despite the drastic treatment occasionally required, for the longer these follicles have existed, the more difficult it is to destroy and obliterate them.

The treatment used by the author is the application of silver nitrate in 50 per cent solution. This must be done with extreme caution to prevent the solution's dropping into the larynx. The applicator is squeezed to prevent any dripping and also is shaken or tapped against the side of the fountain cuspidor as an added precaution.

In the older cases, electrocoagulation is used. This is especially indicated in those patients complaining of a second or even a third relapse. The pulse rate prior to the destruction of the follicles is a good barometer of the severity of the absorption from these foci of infection. In the acute stages, it is invariably above 90 per minute. Twenty-four hours after destruction of the follicles, with or without any added treatment, the pulse rate is below 90.

In the author's experience, based on well over 500 cases, the pulse rate has proved a

good criterion as to when it is safe to allow a patient to return to work. If the rate persists above 90, either there are some undestroyed follicles remaining or the patient has some cardiovascular condition requiring further study.

The foregoing findings, observations, treatment, etc., are given in no effort to prove originality but rather to share a successful method of attack on virus infections. During the past October, a severe endemic of virus pharyngitis occurred locally. The distinction between those cases and the ones seen during the past winter and designated as influenza is an arbitrary and academic differentiation. The treatment is identical, and the destruction of the foci of infection, the virus follicles, is indicated in each instance.

HISTORY OF THE WEST VIRGINIA TUBERCULOSIS AND HEALTH ASSOCIATION

By G. R. MAXWELL, M. D., F. A. C. P.
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In June, 1907, Mrs. S. W. Price of Scarbro, Fayette County, attended a meeting of the American Anti-Tuberculosis League in Atlantic City where she was invested with authority to promote a state-wide organization in West Virginia. In December of that year she organized the West Virginia Anti-Tuberculosis League. Associated with her were Mrs. William O. Dawson, Mrs. Stephen B. Elkins, Mrs. John W. Davis, Mrs. Thomas Fleming, Mrs. Julia Berry, Mrs. W. A. MacCorkle, Mrs. Guy Lane Allen, Dr. George A. MacQueen, Dr. Eugene Davis, Mrs. Malcolm Jackson, Mr. A. M. Scott, Mr. W. E. Glasscock, Bishop Peterkin, Bishop Donahue and Mr. C. W. Dillon.

In 1908 Dr. Harriet B. Jones, of Glendale, West Virginia, was appointed executive secretary. Through her untiring efforts the work was organized and carried on. Working against many odds and with very little financial or moral support she made it possible for hundreds of tuberculous patients to come back as useful citizens. West Virginians owe her a debt of gratitude for the work she accomplished from 1908 to 1921 which is summarized briefly as follows:

1908

In May the Kanawha County League was formed.

The Kanawha County League prepared a tuberculosis exhibit which was shown first in Charleston.

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1909

A tuberculosis nurse was secured for Charleston.

The exhibit was sent to Wheeling, and to towns large and small for a year.

A tuberculosis dispensary was opened in Charleston.

The sale of Red Cross seals was begun.

1910

A tuberculosis nurse for Wheeling was secured.

A tuberculosis dispensary was opened in Wheeling.

1911

Through the efforts of the league, the legislature made an appropriation for a state sanitarium.

1912

The state sanitarium was built at Hopemont.

View Point Sanitarium was opened near Wheeling.

Hillcrest Sanitarium was opened near Charleston.

1913

The state sanitarium with 60 beds was opened.

With the aid of an appropriation made by the legislature, the league was enabled to transport the tuberculosis exhibit in a car, over nearly every railroad in West Virginia, the railroads carrying the exhibit free. Motion pictures were shown in theaters.

Lectures were given in hundreds of schools.

1914

Lectures in schools were continued as was the exhibit, and thousands visited the car.

1915

A tuberculosis survey was made in three counties by a physician and nurse over a period of six months.

Talks on tuberculosis were given in fifteen county teachers' institutes.

1916

Talks were given in fourteen county teachers' institutes.

The Modern Health Crusade was taken up in the schools.

Literature was sent to teachers for pupils in sixteen counties.

1917

Parcel post exhibits were sent to schools.

Articles were sent to newspapers on tuberculosis. Seventy-five thousand pieces of literature were distributed.

Through the efforts of the league an appropriation was made by the legislature for a sanitarium for Negroes at Denmar.

1918

Twenty thousand children were enlisted as Modern Health Crusaders.

An automobile tuberculosis campaign with stereoptican was made through twenty-one counties, chiefly in rural districts; lectures were given and slides shown in schools, churches and movies, and literature was distributed.

A nurse did tuberculosis work in five counties, looking up tuberculous soldiers and others with tuberculosis, giving instruction and literature as to prevention and treatment.

A plea was made to the Council of Defense for buildings for tuberculous soldiers and they appropriated $10,000 for buildings at the state sanitarium.

1919

Through the efforts of the league the legislature appropriated $30,000 for buildings for tuberculous children at the state sanitarium.

Literature was sent to every teacher for pupils in thirty-one counties.

Two nurses and one lay worker in the field were employed, discovering tuberculous cases, giving instructions, talking in schools, distributing literature, arousing a general interest in the conservation of health, and showing the people the necessity of having a county nurse.

During the months of April and May, The Fly, tuberculosis and child welfare exhibits with stereoptican, and lectures given by the lay worker and local persons in one county, created a great deal of interest and were the means of discovering a very large number of cases of tuberculosis.

At the conclusion of 1920 there were a total of 220 beds for tuberculous patients in the sanatoria established.

In November, 1920, Mr. George C. Rowell arrived from New Hampshire to assume the duties of executive secretary. The West Virginia Anti-Tuberculosis League then became known as the West Virginia Tuberculosis and Health Association and the work was reorganized. County surveys were started to determine what the tuberculosis problem was and, incidentally, what other health problems there were in the counties visited. New committees were organized, inactive committees were made active, and the counties urged to take charge of seal sales and cooperate with the state association in carrying on local programs. This plan was continued for a number of years during which these surveys and the local committees were largely responsible for the establishment of a number of county health units and

the employment of a number of full time county health nurses. From year to year during this period a greater demand was created for sanitarium treatment, so that it became necessary for the legislature to make larger appropriations in order to increase the facilities at Hopemont and Denmar. This was followed by the desire of several counties to establish sanatoria, and also led to the establishing of a state sanitarium at Beckley in 1930. Grandview Sanatorium was opened in 1925 in Marshall County and Eastmont in 1926 in Monongalia County.

EARLY CLINICS

The tuberculosis clinic service was very inadequate during the survey period. In the fall of 1925 arrangements were made for the services of a staff member of Hopemont to conduct clinics under the association's direction. This made possible the employment of Dr. Henry G. Wildman, who came to Hopemont from the Cook County Tuberculosis Hospital, Chicago, where he had been on the staff for thirteen years. He served as clinician for several years, visiting many counties where clinics were organized by the state association's two field nurses. This greatly strengthened the program and created the interest that made it possible to establish a state sanitarium near Beckley, now known as Pinecrest. In the meantime, the more prosperous counties were raising more money and were able to employ nurses to devote practically all of their time to tuberculosis work. These counties included Cabell, Kanawha, Raleigh, Wood, Harrison, Marion, Monongalia, Marshall and Ohio. In Wood County the interest led to the establishment of a preventorium.

After the death of Dr. Wildman in August, 1927, the field clinic service lagged for several years until, in the fall of 1930, an appeal was made to the State Board of Control and the Board of Public Works to recommend to the legislature a special appropriation for the work. Ten thousand dollars a year was granted, and the program was administered by the state association in cooperation with its affiliated county seal sale agencies. The appropriation was continued for another two years by the next legislature, with a cut to seven thousand five hundred dollars a year. Three field nurses were employed to organize and follow up clinics in the counties where there was no adequate public health service for that purpose. In the clinic program the main effort was to find tuberculous infection and disease in the minimal stage, with the aid of tuberculin skin test and the x-ray. Many hospitals cooperated so that diagnostic x-rays were made at nominal rates for persons recommended through the clinics.

The clinicians for these clinics were men from the staffs of the state sanatoria and practicing physicians who were interested in tuberculosis and experienced in diagnosing early tuberculosis. This method was found to be more satisfactory than that of having but one full time clinician. The physicians were assigned to clinics which could be reached easily from their homes, thus making it possible for all parts of the state to be reached with less expense.

APPROPRIATION

Since the establishment of this service in July, 1931, the appropriation has been continued by each successive legislature. In 1937 the appropriation was raised to $10,000 per annum, making possible the employment of three white field nurses and one Negro field nurse. In most part, the activities of these nurses were concentrated in territories having no public health nursing service of their own. Later, when the public health nursing service began to lose much of its nursing personnel because of the war, the field nurses rendered supplementary service during periods of clinic organization in the counties most needing it. During most of the period from 1931 to 1940 (the year in which the Bureau of Tuberculosis, West Virginia State Health Department, was organized) almost all of the tuberculosis clinics throughout the state were made possible by the state tuberculosis association and its affiliated county agencies. At

the present time, although the mobile x-ray unit of the Bureau of Tuberculosis makes its rounds of the state, county by county, the association, largely through the field clinic and nursing service, makes possible many clinics where needed, and provides nursing service.

In an effort to extend this service and also to overcome the handicaps caused by so many nurses going into military service, this service was reorganized on July 1, 1943. The state association now maintains only two regular white field nurses, a supervisor of nurses, and one Negro field nurse. The supervisor's duty is to supervise and help field nurses and executive nurses of county associations and to locate and train, in counties needing nursing service, nurses who are not practicing their profession but who would be willing to provide for their territories a few months of service each year. The plan to date has been successful, providing nursing service for several counties which otherwise would have none and also making possible more frequent diagnostic clinics. Under this plan, the state association is operating two portable x-ray units, and employs technicians on a per diem basis to conduct the clinics.

EDUCATIONAL FEATURES

Educational features of the program from the beginning through 1934 included the health habit program for school children known as the Modern Health Crusade. This was adopted by other organizations including the 4-H Clubs, the Boy Scouts, and the Girl Scouts, and also made a part of the course of study for elementary schools throughout the state. In 1928 the state association cooperated with the National Tuberculosis Association in promoting an intensive spring educational campaign known as the Early Diagnosis Campaign. This program has been continued every year and is regarded as an important part of the regular educational program.

In September of 1940, Mr. Rowell died and was succeeded by Mr. Edmund P. Wells as executive secretary. Since that time much of the effort of the state association has been concentrated upon organizing new associations in counties needing them and in reorganizing several associations which had lost effectiveness. At the present time all fifty-five counties have local associations or committees except Barbour, Clay, Grant and Lincoln.

During the 1943 session of the legislature, the state association attempted to have enacted a three-point legislative program: The enactment of quarantine legislation directed at the careless, indifferent tuberculosis victim, the placing of the hospitalization of the tuberculous under medical authority, and the placing of the responsibility of maintaining the tuberculous indigent with the state government. The latter two of these objectives were attained. At a more recent date the quarantine measures needed were set forth in a regulation determined by the state's Public Health Council.

The more recent history of the West Virginia Tuberculosis and Health Association shows greater attempts to extend health education activities and increased activity in the field of vocational rehabilitation. The state association, in cooperation with many of its affiliates, has established the Harriet B. Jones Rehabilitation Fund for assisting deserving rehabilitants in acquiring necessary training.

FOOD FOR FIGHTERS

Our fighting men eat approximately 40 per cent more than they did as civilians. So actually the supplies remaining for civilian consumption are reduced only from 5¼ to 3¾ pounds, or 1½ pounds per day. Of course, the Armed Forces require at least a 3-month supply for men quartered in the United States and a 9-month supply abroad.

The War Food Administration reports that the average weekly diet for a man in training includes 6 1/5 pounds of meat, 7 eggs, 3½ pounds of fresh milk, 1⅛ pounds of evaporated milk, ice cream once a week, 1 pound of butter and other fats, 4½ pounds of bread and cereal grains, 5 pounds of potatoes, 5 pounds of fresh and canned vegetables, 4½ pounds of tomatoes and citrus fruit, and 2 pounds of other fruit.—*Nutritional Observatory.*

Tuberculosis Abstracts

Furnished Through the Courtesy of the West Virginia Tuberculosis Association

To diagnose the greatest possible percentage of unsuspected cases of tuberculosis, to place these people under immediate and adequate care, to render them and the community safe from further spread of their disease, to rehabilitate every patient into a productive member of society—these are our tasks. Diagnostic procedures that guarantee the maximum return in case finding are those that safely apply the clinical lessons of the past to the pressing problems of the present. No thorough clinician relies exclusively upon a solitary diagnostic aid, even when circumstances strongly tempt him to do so.

Tuberculin Test, X-ray and Other Diagnostic Aids

There is now a strong tendency to "diagnose" tuberculosis by short-cut and sometimes slipshod methods. Recently, a few physicians were asked how they would proceed to find all of the tuberculosis among the population of an entire industry or country. One stated that increased red cell sedimentation rate would ferret out all cases. Another would discover them by finding acid-fast bacilli in their sputa. Still another would employ only x-ray film inspection of their chests. Other similar methods were offered. Each physician presented an important phase of an examination, but not one of them was adequate. To achieve a satisfactory diagnosis each one of this group of physicians would have to examine a given individual in his own way, then pool his findings with those of his colleagues—a wasteful and illogical procedure.

There can be no tuberculosis in the absence of tubercle bacilli; therefore, the first phase of an examination is to determine whether bacilli are present. This can be done by the tuberculin test, which is accurate and specific except in the first few weeks after infection occurs, and in acutely ill and terminal cases. Other failures are usually due to the use of impotent tuberculin or to improper administration. Under proper conditions, then, a non-reactor to tuberculin can be told that he does not have living tubercle bacilli in his body. On the other hand, a reactor has at least primary lesions which contain living tubercle bacilli. Exceptionally, and only when all bacilli die, allergy persists for a time, then wanes and disappears. Inasmuch as primary tuberculosis is a prerequisite for the clinical forms, it is of extreme importance to know whether it is present. The tuberculin test provides this information with uncanny accuracy. With the exceptions mentioned, it is with great rarity that the person with clinical tuberculosis fails to react to tuberculin.

The next phase of the examination consists of inspecting the chests of all adult reactors with the x-ray. On the ordinary film 25 per cent of the lung parenchyma is obstructed from view by shadows of such parts as the heart and diaphragm. Films fail to reveal evidence of primary tuberculosis in 70 to 80 per cent of the persons in whom it actually is present. So, too, may lesions of the reinfection type, because of their size and consistency, escape detection. It is a common experience to view a film which appears clear, yet one of the same chest a few months later reveals evidence of disease. Therefore, adult tuberculin reactors whose lungs appear normal should have films at least annually.

After tuberculous lesions of the reinfection type attain macroscopic (gross) proportions, x-ray inspection is by far our best method of detecting their locations when they are in that part of the lung which is visualized; indeed, they cast shadows on an average of two to three years before they cause significant symptoms. However, final diagnoses should never be made from x-ray shadows, since those cast by tuberculous lesions may be indistinguishable from those of numerous other pulmonary diseases, such as sarcoidosis, silicosis, malignancy, fungus infections, abscess, and pneumonia. When a lesion is found, its etiology can usually be determined by other methods.

The present, widely used procedure which begins with x-ray inspection of the chests of large groups of adults is laudable, provided it does not end there. All concerned must be informed that (1) x-ray inspection is done with the unaided eyes and reveals nothing but macroscopic (gross) lesions; (2) one-fourth of the lung parenchyma is obstructed from view by shadows of other parts; and (3) final diagnoses cannot be made with accuracy from x-ray shadows. Thus, the tuberculin test screens out those persons who have living tubercle bacilli in their bodies, and from them the x-ray screens out those who have gross lesions which may be tuberculous. Neither nor both procedures are adequate.

(Continued on page xxxi)

The President's Page

Many of you have received and probably studied a recent survey sent out by the National Physicians Committee titled "The American People, What They Think About Doctors, Medical Care, and Prepayment Plans." If you have not seen this report, I would urge you to get one, and if you have one, I would suggest that you study it thoroughly.

Briefly, it discloses that in July, 1943, the National Physicians Committee employed the largest opinion research group in this country to make the most comprehensive study of people's opinion on medical care that ever has been undertaken in the United States. The survey was independent, unbiased. The accuracy of the findings can not be questioned.

I do not intend to review the report on this short page, but will give you its final conclusion. The report disclosed that only 16% of the American people approve of a 6% payroll deduction from wages for the federal government to provide medical care and hospitalization. But 63% of the American people ask for an easier method of paying the costs of unusual or prolonged illness and of hospitalization.

Sixty-three per cent is a goodly number of people. Such a group by popular demand or by the ballot could, and probably will insist that their wishes be carried out. No, they do not want socialized medicine. Only 16% have asked for that. But, I am sure the 63%, as well as the 16%, will be very well satisfied with a well organized and liberal prepayment plan for hospitalization and medical care.

This demand must be met. Methods have been devised. Mechanisms have been perfected. Plans have been tested. They are satisfactory to a previously unbelievable extent. They are adequate to the need. The period of experimenting is at an end. All we have to do is to see that every community is participating in one of these plans, either locally or in collaboration with some adjacent community. And, by plans I refer to the non-profit plans for hospitalization and medical care, not to those of the private insurance company. These latter plans are widespread throughout our country and have been serving a large number of people. But they are operated for profit, and this middle-man feature is the thing that most of us Medicos do not like.

So I urge each and every one of you in our Association, whether you like it or not, to get behind the movement for prepaid hospital and medical care. See that it is properly managed. See that the patient gets all the benefits to which he is entitled. But make sure that it is a non-profit plan and that it is under the jurisdiction of your local medical profession. Any plan to succeed must have the unanimous support of the local society.

I am happy to say that we in Ohio County have finally adopted a plan for hospital care. It has been a long time in the offing; most of you in the state have been ahead of us, but then you will remember that we are a shy, conservative group. There is only one thing that we are long on, and that is hospitality. So don't forget May 15 and 16. We are looking forward to your coming. I hope you've made your reservation. And as an afterthought, don't forget the wife. Some of us would rather see her than you.

President.

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AS OTHERS SEE US

Although badgering the medical profession has developed into a skilled art (of the baser sort, to be sure), it is by no means a modern innovation. The caustic colonial historian Robert Beverly, in his "History and Present State of Virginia", published in 1705, in discussing the health and diseases of the colonists of the Old Dominion, indulges in the sarcasm that the Virginians of his day "have the happiness to have very few doctors, and those such as make use only of simple remedies, of which their woods afford great plenty. And indeed, their distempers are not many, and their cures are so generally known that there is not mystery enough to make a trade of physic there, as the learned do in other countries to the great oppression of mankind."

Since the days of the first native Virginia historian, sarcastic literary barbs directed at the medical profession have become keener and more venomous, but are still as unjust and unjustified as ever. In fact, a favorite indoor sport among some of the modern star-gazing "uplifters" sojourning in the national capital is baiting the medical profession and berating that great organization of physicians, the American Medical Association. Such a poisoned (and inaccurate) shaft has recently been launced against the office of the Surgeon General of the Army by a commentator, well informed in lay subjects, who apparently does not understand the difference between an osteopath and a chiropodist.

Most of such propaganda probably does little harm, but it is so constant and so insistent that it behooves the men of medicine to be constantly on their guard and ever ready to combat all such insinuations. In our humble judgment, this can best be achieved by establishing an office of information in Washington where information upon medical subjects may be had by all comers. Such an office should be primarily an educational agency to which legislator and citizen alike could appeal for authoritative information on all phases of medicine and health. As to just what organization should establish such an office of information, we have not yet reached a definite conclusion, but certainly it should represent all segments of the profession of the United States.

An outstanding organization representing the entire profession is the National Physicians Committee. In our next issue we expect to publish a paper from the facile pen of Dr. Edward H. Skinner setting forth the accomplishments of that great group, one of whose outstanding performances has been a recent public opinion survey made to learn the opinion of the American people about medical care and medical organization. Commenting editorially upon this survey in its March 11 issue, the *Journal of the American Medical Association* says:

"In July 1943 the National Physicians Committee employed the largest opinion research group in this country to make a comprehensive study of the people's opinion about medical care. The results of that study have just been made available. In making this survey the National Physicians Committee has rendered a distinguished service to American medicine. The report should be of great help to medical leaders by pointing the way in planning for the extension of medical service. The report indicates the necessity for more education of the public regarding the issues involved in proposals for changing the nature of medical service. When people understand the issues, an overwhelming majority are unqualifiedly opposed to any such proposals as the

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OF PHILADELPHIA

Wagner-Murray-Dingell bill, which would establish federal control of medical practice. Even though the people sense the need for the extension of facilities designed to meet the costs of unusual or prolonged illness, only a small minority, as shown by this report, believe that compulsory sickness insurance would provide a satisfactory solution to the problem.

"Many of the questions in this research concerned the personal experiences of the people with medical care as now provided in the United States. The replies, in great majority, indicated that the people are deeply conscious of the value of individualized service in the effectiveness of medical care, that they want complete freedom of choice in time of illness and that they believe choice would be limited and restricted by administration of medical care under the auspices of the federal government.

"Out of this report came the conviction that many persons find difficulty in meeting bills for unusual or prolonged illness and desire to participate in plans or methods for insurance against the hazards of emergency illness. Already great numbers of people are familiar with the various prepayment plans for medical service available throughout the country. The investigations extended into many communities in which such plans are operating and covered the experiences of the participants. To summarize the many questions asked on this phase of the report: Persons who participate in prepayment plans approve them; in every instance such persons believe they are better off than their neighbors who have no such opportunity; the doctors in areas where such plans are in operation believe that the people are better off because of the operation of the plan. More than 50 per cent of the doctors in such areas stated that it would be a good thing if all industries would operate prepayment medical and hospital service plans for their employees.

"In a special survey paralleling the study of medical service, opinion was sought concerning the American Medical Association. More than three fourths of the people who were questioned had heard of the American Medical Association, and about half of these defined its purposes with reasonable accuracy. In general, those who had heard of the American Medical Association expressed approval. The inquiry about the American Medical Association was made in the survey to determine the extent to which mention of the public education activities of the medical profession would tend to have a favorable or unfavorable influence on public thinking. The best evidence that the American Medical Association was considered a 'favorable symbol' was the fact that most people think of the purposes of the American Medical Association as being 'to sponsor new medical technics; to keep the standards of medical practice high; to give endorsement to acceptable medical products.' Moreover, less than one tenth of the people interviewed thought of the American Medical Association as a 'union' of physicians or as a 'trust' or as being otherwise primarily a self-interested body.

"The report of this survey, which is available through the National Physicians Committee, should do much to counteract the irresponsible and sometimes malicious criticisms that have been expressed recently within and without the medical profession. The scope and the accuracy of this survey cannot be questioned. The results are a challenge to medical leadership. Only through enlightened medical leadership can medical service and medical science continue to evolve in the United States beyond the high point that they have now attained. The advancement of medical science and of medical education is fundamental to the quality of medical service. Some of the proposals that have been made to federalize medical service, coming from outside the medical profession, would subsidize education and research. From within have come proposals to 'unionize' or 'commercialize' medical service. The professional status of medical care and medical science must be maintained. The economic factors involved in securing wider distribution of medical service must be studied and the widest possible application of these services secured. But even the economics of medical service must always be dependent on the science, the art and the practice of medicine."

Considering the accomplishments of the National Physicians Committee and the great scope of its work, we bespeak for it both moral and financial support. Why could it not open an office of information in Washington?

OUR TWO ARMY HOSPITALS

Hundreds of sick and wounded soldiers from every battlefront in the world are receiving treatment at Ashford General Hospital (formerly the world-famous "Greenbrier"), at White Sulphur Springs. Boys are there from the jungle war. Others have gone through battles in North Africa, Sicily and Italy that have helped change the map of the world.

Each and every one of these unfortunate heroes is being given the best possible medical and surgical treatment. Hundreds have been cured and returned to their outfits. Others have been rehabilitated to the extent that they are now able to earn their own living. Still others are undergoing treatment in the promise that they will eventually be restored to good health.

While Ashford General has been operating successfully for several months, the Newton D. Baker General Hospital at Martinsburg has just recently been opened. Eventually beds will be provided for 1750 patients. In a news article appearing elsewhere in this issue of The Journal, an overall picture of this new Army hospital is given. There, as at Ashford General, splendid work is being done to restore our wounded soldiers to the Army or to civilian life. There, too, the best possible medical care is being provided.

Thus, in two widely separated parts of West Virginia, Army doctors are working

hard each day to bring into the lives of these boys who have risked their all for their country at least the hope of complete restoration to health so that they may at the war's end lead a normal life and again become useful citizens of their country.

LIVING PAST PRESIDENTS

Next month, doctors from all over West Virginia will gather at Wheeling for the first annual meeting to be held in that city since 1935. Not since 1937, when the late Dr. W. S. Fulton, of Wheeling, was president, has any meeting of the West Virginia State Medical Association been held in the northern part of the state.

At the Wheeling meeting in 1935, the late Dr. Rome H. Walker, of Charleston, presided as president. At that meeting, Dr. Charles G. Morgan, of Moundsville (now in active practice in Corpus Christi, Texas), was elected president.

Dr. T. M. Hood, of Clarksburg, now in his 91st year, is the oldest living past president of the Association. He was elected at the meeting in Fairmont in 1904 and presided at Wheeling the following year. Besides Doctor Hood, the list of past presidents, still living, includes the names of Drs. T. W. Moore, Huntington; C. A. Wingerter, Wheeling; Robert J. Reed, Sr., Wheeling; H. R. Johnson, Fairmont; J. Howard Anderson, Hemphill; John N. Simpson, Morgantown; Robert A. Ashworth, Moundsville; George D. Jeffers, Parkersburg; James R. Bloss, Huntington; C. R. Ogden, Clarksburg; Walter E. Vest, Huntington; D. A. MacGregor, Wheeling; Roy Ben Miller, Parkersburg; Charles G. Morgan, Corpus Christi, Texas; Ray M. Bobbitt, Huntington; Frank V. Langfitt, Clarksburg; Robert King Buford, Charleston; R. O. Rogers, Bluefield; and, R. J. Wilkinson, Huntington.

An effort is being made to have all these past presiding officers attend the annual meeting at Wheeling. While it is realized that some few will be unable to do so on account of their inability to leave their practice at that time, it is hoped that most of them will find it convenient to make the trip. The presence of these past officers will help make the convention a success.

DOCTORS WILL HEED CALL

April will be observed as "Cancer Control Month" throughout the country. Here in West Virginia, the annual campaign of the Women's Field Army will get under way shortly after the first of the month.

The need for early diagnosis in the successful treatment and control of cancer, education in the homes and schools, and the enlistment of women in the important work that is being done, are some of the things that will be discussed in the newspapers, on the radio and by personal contacts by the members of this organization which is composed of over three hundred thousand women pledged to wage war against this disease.

In an appeal to the people to support the organization and thus help in the fight against cancer, Clarence Cook Little, Sc. D., Managing Director of the American Society for the Control of Cancer, states that "it has been said that cancer is the most curable of the fatal diseases." That is an interesting statement and is not a contradiction of itself, as it might at first seem to be. Its justification lies in the very nature of cancer, for cancer in its early stage is localized, limited, and capable of being completely removed or destroyed.

Continuing, Doctor Little says: "The picture, however, is far from being a gloomy one. Each year more and more people are learning that 'time' is the keyword in cancer control. Each year thousands more people are coming to their doctor with very early signs and symptoms that may mean cancer. As a result, they are being treated in time to prevent cancer or to cure it if the malignant process has already begun. The value of annual or semiannual physical examination is becoming clearer to an ever-increasing number of men and women.

"Cancer prevention clinics, where perfectly well persons report periodically for a physical 'check up,' have been established in some cities and are doing excellent work. The idea will spread and grow. Lives will be saved, suffering avoided. Death will be cheated. Americans of the future will visit such clinics as a matter of routine."

The Division of Cancer Control, just set up in the State Health Department under Dr. Paul R. Gerhardt, needs the active support, not only of the Women's Field Army, but of the doctors of West Virginia. The call for service in this great fight has never gone unheeded by members of the profession, and this year will prove no exception. Our doctors will be found in the front lines fighting to help educate the people of West Virginia to the need for early diagnosis.

NEW APO AND FPO ADDRESSES

Capt. Harry E. Baldock, MC,
APO 784,
c/o Postmaster, New York, N. Y.

Capt. Arthur R. Gersabeck, MC,
APO 230,
c/o Postmaster, New York, N. Y.

Major Everett W. McCauley,
APO 572,
c/o Postmaster, New York, N. Y.

Lt. Col. S. S. Hall, MC,
APO 9641,
c/o Postmaster, San Francisco, Cal.

Capt. Herbert N. Shanes, MC,
APO 650,
c/o Postmaster, New York, N. Y.

Comdr. James K. Stewart (MC), USNR,
FPO 814,
c/o Postmaster, New York, N. Y.

Capt. Dewitt T. Bond, MC,
APO 913,
c/o Postmaster, San Francisco, Cal.

Capt. Paul R. Wilson, MC,
APO 928,
c/o Postmaster, San Francisco, Cal.

Major A. C. Chandler, MC,
APO 629,
c/o Postmaster, New York, N. Y.

PHC TO MEET MAY 1-3

The regular spring meeting of the Public Health Council of West Virginia will be held at Charleston, May 1-3, for the purpose of examining applicants for license to practice medicine in West Virginia.

General News

COMMITTEE ANNOUNCES TENTATIVE PROGRAM FOR 77TH ANNUAL MEETING

The program for the 77th annual meeting of the West Virginia State Medical Association at Wheeling, May 15-16, has just about been completed.

The convention, which will be held in the ballroom at the Windsor Hotel, will be formally opened Monday, May 15, at 9:30 A. M. The address of welcome will be delivered by Dr. Arley V. McCoy, president of the Ohio County Medical Society, and the response will be made by Dr. Frank V. Langfitt, of Clarksburg, past president of the State Medical Association.

The scientific program, which has again been streamlined to two days, will feature addresses by speakers of national prominence. While the program has not been completed, it is known that the following speakers will appear: Dr. S. A. Cosgrove, Medical Director and Superintendent Margaret Hague Maternity Hospital, Jersey City, "The Medical and Surgical Complication of Pregnancy"; Dr. Walter C. Alvarez, Mayo Clinic, professor of medicine at University of Minnesota Graduate School of Medicine, "What is the Matter with the Patient Who is Always Tired"; Dr. Richard B. Cattell, Lahey Clinic, Boston, "Surgery of the Upper Gastro-Intestinal Tract."

Invitations have also been accepted by the following: Dr. F. H. Adler, professor of ophthalmology at the University of Pennsylvania, Philadelphia; Dr. W. W. Waddell, associate professor of pediatrics at the University of Virginia Department of Medicine, Charlottesville; and, Major Ralph H. Kunstadter (MC), AUS, chief of the communicable disease section at Ashford General Hospital, White Sulphur Springs.

The annual address of the president will be delivered by Dr. R. J. Reed, Jr., of Wheeling, following the dinner meeting of the past presidents of the State Medical Association.

The oration on surgery will be given by Lt. Comdr. J. O. Rankin (MC), USNR, (Wheeling), U. S. Naval Hospital, Memphis, Tennessee, at the afternoon session the first day. Dr. Andrew E. Amick, of Charleston, member of the Council

and immediate past president of Kanawha Medical Society, will deliver the oration on medicine, which is scheduled for the afternoon program the second day.

Prominent Army and Navy speakers will appear on the program the afternoon of the second day, and it is probable that a "war participation dinner" will be arranged for Tuesday evening.

The first meeting of the House of Delegates will be held Monday afternoon, May 15, at 4:30 o'clock. The second and final session is scheduled for the same time Tuesday afternoon.

The scientific program, which is being arranged by the Scientific Work Committee, composed of Drs. R. D. Gill, Wheeling, chairman; J. P. McMullen, Wellsburg, and Thomas L. Harris, Parkersburg, will be completed shortly after the first of April. Scientific exhibits are being arranged by a committee composed of Drs. Hu C. Myers, Philippi, chairman; John P. Helmick, Fairmont, and Fred Whittlesey, Morgantown, and will be set up in the sun room, just off the lobby. All technical exhibit space has been sold and it has even been necessary to arrange for extra booths in the lobby.

While a few desirable rooms are left at the convention hotels, the Windsor and the McLure, it is important that reservations be made without delay. There is always a shortage of suitable hotel accommodations at Wheeling, but the management at the two hotels has reserved whole blocks of rooms for the use of guests at the meeting of the State Medical Association.

SYPHILIS COMMITTEE MEETS APRIL 26

A meeting of the Syphilis Committee of the West Virginia State Medical Association will be held April 26 at the new Kanawha Valley Medical Center at South Charleston. The committee is composed of Dr. Carl A. Hoffman, of Huntington, chairman; and, Drs. Howard T. Phillips, Wheeling; L. E. Neal, Clarksburg; and, M. L. Bonar, Charleston.

WEST VIRGINIA NURSES PROMOTED

Kathryn R. Kerrigan, of Weston, Nell L. Baxter, of Jane Lew, and Opal M. Jones, of Hinton, all Second Lieutenants in the Army Nurse Corps, have been promoted to the rank of First Lieutenant. Lieutenants Kerrigan and Baxter are serving with Col. Charles F. Fisher's "St. Mary's Unit," somewhere in Italy.

ANNUAL STATE HEALTH CONFERENCE SET FOR CHARLESTON EARLY IN MAY

Health officers and workers, as well as others interested in safeguarding the health of the people of West Virginia, will have the opportunity to participate in a tropical diseases forum in connection with the annual meeting of the West Virginia State Health Conference, May 1-2, at Charleston. The entire morning of the second day has been set aside for a discussion of tropical and war-time diseases of probable public health importance in the United States.

The various phases of the diseases to be discussed include clinical diagnosis and therapeutics, laboratory and field control, and etiology and epidemiology. An invitation has been extended to all the doctors in West Virginia to attend the conference, as it is believed that the subject of tropical diseases has a very definite place in post war planning.

All sessions of the conference, which is a joint meeting of the West Virginia Public Health Association and Health Officers Conference, will be held at the Daniel Boone Hotel. The first session will be held Monday, May 1, at 9 A. M., with Dr. J. E. Offner, state health commissioner, presiding. The conference will close the following evening with the annual dinner, at which Dr. W. K. Sharp, Jr., Director USPHS, District 2, Bethesda, Maryland, will preside.

Besides the symposium on tropical diseases, the following program will be presented at the two-day meeting: "Newer Methods of Communicable Disease Control," Dr. L. F. Badger, Assistant Director, National Institute of Health, Bethesda, Maryland; "Rural Health," Dr. P. E. Blackerby, State Health Commissioner, Louisville, Kentucky; "Nursing," Hortense Hilbert, Associate Director, National Organization of Public Health Nursing, New York; "Emergency Maternal and Infant Care Program," Dr. Arthur J. Lesser, Regional Medical Consultant, Children's Bureau, Washington; and "Venereal Disease Control," Dr. U. J. Wile, Medical Director, School of Public Health, Ann Arbor, Michigan.

WESTON DOCTOR COMMISSIONED

Dr. Claude R. Davisson, of Weston, who has been serving as a resident at Mercy Hospital, Baltimore, has been commissioned a First Lieutenant in the Army and ordered to active duty.

NEWTON D. BAKER GENERAL HOSPITAL AT MARTINSBURG NEARING COMPLETION

The new Newton D. Baker General Hospital, near Martinsburg, West Virginia, covers 30 acres on a military reservation consisting of 186 acres. Construction was begun during 1943 and the first patients were admitted in January, 1944. All basic features of the installation have been completed, though considerable work still continues on features not absolutely necessary to the functioning of the unit.

The hospital is built on the standard plan of the Army's general hospitals, with certain variations. A two-story administration building connects by corridors with the rest of the installation. Corridors connect all buildings, so that it is not necessary to expose the patient at any time to climatic changes.

Besides the administration building, the only other two-story buildings erected are the bachelor officers' quarters and the nurses' quarters.

In the rear of the administration building, the x-ray and physical therapy building, the laboratory building, and the EENT and Dental building, all corridor-connected, are located. A long corridor connects with the first bank of wards, each ward an individual building. Farther back along the corridor is the post exchange, post office, Red Cross and patients' auditorium, as well as a long-distance telephone unit. Following in order is the second bank of wards, with occupational therapy building, library and general mess hall, receiving office and supply buildings — medical, quartermaster, and laundry. Not attached by corridors are the hospital's heating plant, the post engineer's office and officers' club, as well as the fire department, which is equipped with three trucks.

The entire group consists of approximately 80 buildings, including those not corridor-connected. Walls are of masonry, and construction is of a semi-permanent type. An automatic fire-control system augments the protection afforded by the fire department.

A feature noted by most medical visitors is the compactness of the buildings housing the various professional services—the EENT and Dental building, laboratory, x-ray and physical therapy, and surgery. These are connected by a corridor enabling travel through all these buildings in the space of a few minutes.

Space between the buildings is laid out in avenues and streets. A chapel is attached by corridor, as is the guest house under the management of the Red Cross, where relatives of patients may secure lodging for a few days while visiting them.

Water is secured from three wells, and that used for washing, cooking, etc., is softened. Air-conditioned wards are provided for postoperative cases. A gymnasium is now in the process of construction. A laundry, modern in every respect, takes care of all washing needs.

The post exchange—the Army's famed "PX" which follows the fighting men of America everywhere—includes a lunch counter, a merchandise store stocking standard PX items, clothing sales shop, cleaning and pressing shop, and barber shop.

Recreational and educational needs of the patients are taken care of by the hospital's special services branch and the Red Cross.

A theatre building is in the process of construc-

Administration Building, Newton D. Baker General Hospital, Martinsburg.

tion. Moving pictures are now shown in the gymnasium. Portable moving picture units are moved through the wards for bed patients. When fully completed, all wards containing patients unable to move will be wired for sound, so that entertainment broadcast from the patients' auditorium, or from outside, can be received by all.

Over 1100 patients are now receiving treatment at the hospital, which, when completed, will accommodate 1750 patients. Colonel E. L. Cook is the commanding officer, and the permanent personnel will consist of several hundred officers, nurses and enlisted men.

RELOCATIONS

Dr. J. L. Roark, who has been located at Kimberly for several years, has moved to South Charleston.

* * * *

Dr. F. J. Zsoldos has located at Glen Rogers, having moved there from Pineville.

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Dr. Karl H. Trippett will move to Galloway the first of April. He has been located at Mabscott, near Beckley, for several years.

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Dr. C. F. Johnston, of Welch, has moved to Charlottesville, Virginia, where he is attached to the staff of University Hospital.

* * * *

Dr. Harry A. Smith, formerly of Charleston, has moved to Huntington.

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Dr. Reuben Rubisoff, of Logan, is now attached to the staff of Columbia Hospital, at Columbia, Miss.

* * * *

Dr. John W. Yost, who has been connected with the Williamson Memorial Hospital, at Williamson, has moved to Princeton, where he will engage in general practice.

* * * *

Dr. Joseph M. Foley, who moved from Peoria, Illinois, to Wheeling in 1939, has returned to that city, where he has relocated for practice.

PRE-CONVENTION MEETINGS

The annual meeting of the publication committee of the West Virginia State Medical Association will be held Sunday, May 14, at the Windsor Hotel, Wheeling, and will be followed by the preconvention meeting of the Council.

"DOCTOR" LIEBOWITZ, ALIAS STRAUSS, IN SOUTHERN WEST VIRGINIA AGAIN

"Doctor" Samuel Seymour Liebowitz, alias Samuel Seymour Strauss, alias Charles Freeman Krueger, who was very much in the medical headlines in West Virginia in 1940-41, has reappeared in the southern part of the state. Invading the coal fields east of Charleston, he applied for work as an assistant in industrial medical practice. He stated that he was a graduate of a foreign school, had taken his junior and senior years in medicine at the University of Pennsylvania, and was licensed in Missouri and New York. He said further that he was at that time employed as a member of the staff at Spencer State Hospital (mental) at Spencer, and that the Public Health Council had given him a special permit to practice at that institution.

As a matter of routine, the case was referred to the West Virginia State Medical Association headquarters at Charleston for investigation, and it was found that no person by the name of Liebowitz had ever been connected with the Spencer institution, and that no special permit to practice had ever been granted by the Public Health Council to a doctor by that name.

Liebowitz, advised by the doctor in the coal fields to get out of West Virginia and stay out, left immediately. Less than a week later, on March 21, he turned up in Charleston and on some trivial pretext came to the offices of the State Medical Association. After considerable questioning, he admitted that he was the same Liebowitz who "practiced" in the coal fields of West Virginia in 1940 under the name of "Dr. S. S. Strauss", posing as a graduate of Long Island College of Medicine, and as a regularly licensed physician in West Virginia.

He also admitted that he had served time in the Federal reformatory at Chillicothe, the Northeastern Penitentiary at Lewisburg, Pennsylvania, the U. S. Penitentiary at Atlanta, and the U. S. Penitentiary at Terra Haute, Indiana.

The federal court records in West Virginia show that at the March, 1941, term of the U. S. District Court for the Northern District, at Parkersburg, Liebowitz was convicted on a charge of falsely and incorrectly registering for the draft and sentenced to serve two years at Atlanta. He states that he was later transferred to Terra Haute. He was paroled from the Terra Haute prison October 26, 1942, and placed under the jurisdiction of the U. S. probation officer at South Bend, Indiana.

His conviction at Parkersburg in 1941 followed months of posing as a doctor and "practicing" in various parts of the country, including relief work in many towns in the coal fields in West Virginia. The case was at that time reported in several issues of THE WEST VIRGINIA MEDICAL JOURNAL and in the January 4, 1941, issue of the *Journal of the American Medical Association.*

At the completion of a thorough investigation by federal officers, report was made to the West Virginia State Medical Association that Liebowitz had had no medical training whatsoever, but had worked as an orderly in federal reformatories.

Liebowitz, while freely admitting the truth of most of the evidence with which he was confronted, stoutly maintained that he is a graduate of the "University of Vienna", class of 1939, and that he had interned at "Westminister Hospital, London," in 1940, coming to the United States in March, 1940. He stated that he had had several jobs since his parole from Terra Haute, working in Whiting, Indiana, and at Louisville, Kentucky. He said he came back to West Virginia because he had no work and because he is "qualified to practice medicine in the coal fields."

So far as is known, Liebowitz has contacted no doctor in West Virginia since he was investigated the middle of March. At the time of his visit to Charleston, he was advised to leave West Virginia without delay. Exhibiting a bus ticket, he said he had decided to try to get work on a farm, and was leaving that afternoon for Philadelphia.

Members of the profession in West Virginia are requested to be on the lookout for "Doctor" Liebowitz and to notify Dr. J. E. Offner, State Health Commissioner and Secretary of the Public Health Council, if he should turn up in their community.

STATE MEDICAL MEETINGS

The following is a list of annual meetings scheduled by some of the state medical societies for the month of May, 1944:

Date	*State*	*Place*
May 1-4	Nebraska	Omaha
2-4	Ohio	Columbus
2-4	Connecticut	Bridgeport
7-8	California	Los Angeles
7-9	North Dakota	Fargo
8-11	New York	New York City
9-10	Mississippi	Jackson
9-12	Georgia	Savannah
10-11	Kansas	Topeka
10-11	Texas	Dallas
15-16	**West Virginia**	**Wheeling**

LENGTH OF MARRIED LIFE INCREASES

According to current mortality, the average couple, at the time of marriage, has a prospect of married life five years longer than would have been its share under the mortality of 20 years ago. For example, a groom 25 years old and a bride of the same age may expect to live together 37 years on the average, according to mortality conditions in the white population of the U. S. in 1939-41.

About 25 years of married life remain, on the average, to husbands and wives when both are 40 years old. The expectation runs much higher, of course, for young married people. When each of the marital partners is age 20, the joint expectation is as high as 41 years. Even at age 65, when the husband is ready for retirement, he may expect to share the next 8½ years with his wife, if she is of the same age.—*Metropolitan Life Insurance Company Statistical Bulletin.*

OUR DAY

Many generations ago Horace said:

> "Happy the man—and happy he alone,
> Who can call today his own,
> He who secure within can say,
> Tomorrow, do thy worst—for I have
> lived today."

One summer afternoon in Camden, New Jersey, Walt Whitman, after greeting a group of friendly workmen, turned to his physician, William Osler, and said: "Ah, the glory of the day's work, whether with hand or brain! I have tried 'To exalt the present and the real, to teach the average man the glory of his daily work or trade'."

Great poets and great physicians have much in common. Their highest services to humanity are equally dependent upon absolute freedom of thought and freedom of action. Can you imagine Walt Whitman or William Osler reading a bureaucratic bulletin for daily guidance. Certainly not in Walt Whitman's America!—*Journal of the Oklahoma State Medical Association.*

ETERNAL VIGILANCE

There is one common communicable disease that seldom flaunts a rash, that does not start with a high fever, that fails to herald its approach by means of sore throat, overwhelming malaise, violent headache or major digestive upset. That disease is tuberculosis, and the time of the year to watch out for it is exactly twelve months long! — *Minnesota Medicine.*

WITH DOCTORS IN THE SERVICE

Col. Charles F. Fisher, M. C., of Clarksburg, was in command of the first station hospital to land in Italy, or in Europe. The unit, which is now serving in Italy with the Peninsular Base Section, made a beach landing early last October, close on the heels of the retreating Germans, and just a few hours behind Lt. Gen. Mark W. Clark's troops.

Recruited by Colonel Fisher over a year ago, the unit, which is composed of West Virginia doctors and nurses, is known as "the St. Mary's Unit." His report by letter of the important work being done in Italy at the present time is therefore doubly interesting to the members of the West Virginia State Medical Association, both at home and abroad. Colonel Fisher's letter follows:

APO 389
c/o P. M., New York, N. Y.
21 February 1944

Charles Lively, Executive Secretary,
West Virginia State Medical Association
Charleston, West Virginia

My dear Mr. Lively:

My only excuse for not answering your kind letter of some time ago is that we have been extremely busy here in the combat area.

I am enclosing pictures of the officers in this organization who are residents of West Virginia. A roster corresponding to the picture locations is attached to both pictures, the nurses from West Virginia being properly identified. We hope that you will find them interesting.

This unit was organized by the undersigned, and we trained at Lawson General Hospital, Atlanta, and activated at Camp Forrest, Tennessee. In the early days of August, 1943, we were shipped to an Atlantic P.O.E. and sent directly to Africa, landing at Oran, in Algiers.

We were assigned to the Fifth Army a month later to take part in the Italian invasion. We arrived here very early in October. Our first two days were spent at a fairgrounds, one of Mussolini's showplaces. We made a beach landing on our arrival in Italy. Recently each member of this organization received bronze battle stars for participation in the campaign.

The hospital is located in the heart of a fashionable Fascist area. The hospital building was formerly the high school for the district. It is modern and of concrete and

WEST VIRGINIA DOCTORS ATTACHED TO STAFF OF "ST. MARY'S UNIT," SOMEWHERE IN ITALY

Seated, Left to Right: Capt. Raymond B. Nutter, Lumberport; Capt. Samuel Weisman, Parsons; Lt. Col. R. Harold Jones, Fairmont; Col. Charles F. Fisher, Clarksburg; Lt. Col. Robert W. Lukens, Wheeling; Capt. Joseph Gilman, Clarksburg.

Middle Row: 2nd Lt. Emil Capito, Chester; Major Robert T. Humphries, Clarksburg; Capt. Carl A. Laughlin, St. Marys; Capt. John F. McCuskey, Clarksburg.

Top Row: 1st Lt. Chester F. Ali, Clarksburg; Capt. Paul L. McCuskey, Wheeling; Capt. Wm. H. Allman, Clarksburg; Major Francis E. Van Horn, Wheeling.

marble construction. This building played a very prominent part in the campaign. We were delayed one day getting into it as a large funeral took place to dispose of the dead filling our first floor halls.

At this time the front was only a few miles away and the Germans had left only four days before. We were without light, heat, or water. Within four days, the hospital was operating full-strength, receiving and caring for patients, and still with none of the conveniences mentioned. Our bed capacity became twice its expected number. The officers and nurses are quartered in a modern six-story apartment house. The occupants had fled to Rome with the Germans. The detachment is quartered in apartments near the hospital.

We have been bombed over ten times with no accidents. There was one near miss (across the street). In turn, we have functioned as an evacuation hospital, general hospital, and station hospital. We have been busy at all times. Morale is high. Food is excellent.

I served as Senior Medical Officer and, as such, Transport Surgeon in the convoy over from the United States. I also served as Senior Medical Officer in the convoy from Africa to Italy. In the latter position we functioned with the British. Our association with the British has been pleasant and cooperative.

Our patients range from privates to generals. By the way, this hospital was the first station hospital to land in Italy, and therefore Europe as well.

Curfew and blackout are rigidly enforced. There is plenty to see and hear. For entertainment, there are operas, concerts, movies, shows, etc., and we have sufficient time for needed relaxation. The Red Cross is doing a great work here and deserves even more support than it is getting at home.

At this time we have lights, heat, and water. The health of the members of the unit has been good.

We thank you for the Journal which is received regularly. The department with news of those in the service is most interesting. We have no occasion to neglect our medical reading and study. Our library is excellent. We attend meetings of two military medical societies, of which we are members. We visit hospitals in this area, including civilian institutions, for the purpose of studying typhus. The Army affords every opportunity to the members of its medical organizations to increase their knowledge of everything pertaining to the practice of their profession.

Each member of this organization joins with me in sending sincere regards to all of our friends. Happy Easter.

Sincerely,
Charles F. Fisher, Colonel, M. C.

* * * *

Capt. V. L. Peterson, of Charleston, who has been stationed at Fitzsimons General Hospital, Denver, for several months, is now attached to the staff of Winter General Hospital, at Topeka, Kansas.

* * * *

Dr. A. L. Osterman, of Wheeling, who is assigned to the U. S. Naval Hospital at Quantico, Virginia, has recently been promoted to the rank of Commander.

* * * *

Captain William L. Claiborne, of Huntington, has completed a course in tropical and military medicine at the Army Medical School, at Washington, and has been reassigned to the 135th General Hospital, at Fort Benning, Georgia.

ARMY NURSES ATTACHED TO "ST. MARY'S UNIT"

Seated, Left to Right: Wilma A. Day, Marietta Liedy, Carolyn J. McPhail, Mary L. Coyne, Salem; Maxine H. Kalberg, Dorothy M. McManus, Helen E. Dixon, Evelyn H. Conklin, Margaret L. Donahue, (1st Lt., Chief Nurse), Clarksburg; Ida R. Baier, Helen N. De Pollo, Thomas; Lillian W. Harrod, Margaret L. Willis, Kempton; Edith Sheeley, Maxine E. Boudman.

Middle Row: Evelyn J. Grose, Mabel L. Anderson, Mary D. Brooks, Selbyville; Rita D. Storch, Wheeling; Catherine M. O'Brien, McMechen; Mary E. Joyner, Hazel E. Gregory, Sara J. Eckard, Anne J. Henthorn, Wheeling; Evelyn Morris, Mary E. Rhyne, Hilda R. Peace, Ruth M. Sheppard, Reedy; Doretta N. Hamilton, Mole Hill; Bonita M. McGuire, Bridgeport.

Top Row: Nell L. Baxter, Jane Lew; Kathryn R. Kerrigan, Weston; Jeanne D. McCutcheon, Green Bank; Agnes M. Cooper, Weston; Ruth U. Mellett, Beulah M. Smith, Fairmont; Agnes E. Bergendahl, Nell Romine, Jane Lew; Ethel B. Hurley, Patricia L. Quinn, Lost Creek; Marlys K. Siegloch, Grace G. Grimes, Fairmont; Celine G. Dulude, Anna L. Schons, J. Ethel Diani.

Not in Picture: Pearl F. Dolinger, Dorothy L. Harris, Elm Grove; Geraldine G. McHugh, Mary E. McNeill, Mannington; Jessie B. Propst, Bronn Washam.

Dr. P. A. Haley, III, of Charleston, who is stationed at the U. S. Naval Ordnance plant at South Charleston, has been promoted to the rank of Commander.

* * * *

Dr. Emery W. Garred, of Milton, who is assigned to the Station Hospital at Fort McClellan, Alabama, has been promoted to the rank of Major and named as Chief of Surgical Service at that hospital.

* * * *

Captain Arthur R. Gersabeck, of Maybeury, who has been stationed at Camp Forrest, Tennessee, is with our armed forces in England.

* * * *

Dr. James R. McClung, of Wheeling, who is overseas, has been promoted from the rank of Captain to Major.

* * * *

Dr. John F. Stecker, of Morgantown, who is assigned to the A. A. F. Station Hospital at Florence, S. C., has been promoted from First Lieutenant to Captain.

* * * *

Major Paul R. Revercomb, of Charleston, who has been attached to the staff of the 246th Station Hospital, at Camp Sutton, North Carolina, is now assigned to Stark General Hospital, at Charleston, South Carolina.

* * * *

Lt. Comdr. Ray H. Wharton (MC), USNR, of Parkersburg, is assigned to the U. S. Naval Hospital at Key West, Florida.

* * * *

Captain Grover C. Hedrick, Jr., of Beckley, writes most interestingly concerning his travels in Italy. He has visited Naples, Foggia, Bari, and Taranto. Following up one of his patients, he found him in the Station Hospital (St. Mary's Unit, Clarksburg) of which Col. Charles F. Fisher is the commanding officer. He states that he was given a warm welcome by all the West Virginia doctors assigned to this hospital. "The West Virginia Medical Journal," he writes, "keeps me abreast of the problems and current medical events of civilian practice. The articles printed in The Journal are well chosen and have been of great help to me in my practice in the Army."

* * * *

Captain L. J. Pace, of Princeton, who is stationed in England, writes that he has not seen any doctor from West Virginia since he has been overseas. "I think that the Army has deliberately given me assignments where there are no folks from West Virginia or from the University of Virginia, where I attended medical school," he writes. "I did see Captain Julian Kaufman and Captain Dan Glassman, of Charleston, and Lieutenant Chandler, of Logan County, while I was stationed at Camp Rucker, Alabama." After reporting that he is assigned to a large station hospital, Captain Pace continues:

"The majority of the doctors stationed here are from the south. A few are from New York and Ohio. All of the nurses are from the midwest. Because of the censorship, I am not permitted to tell you what I have been doing. However, I can tell you that I have a very nice assignment doing surgery, the kind most of us would like to do.

"Our hospital is established in permanent buildings which are well heated and very well equipped. Our operating rooms have excellent facilities. The hospital is located in one of the very best sections of England.

"I suppose that everyone who has written to you has told you of the beauty of England. Even at this time of year (February 27), the fields are green. All homes and buildings are constructed of brick and rock. One seldom if ever sees a wooden structure. However, many of the homes are covered with thatched roofs which add to the quaintness and picturesqueness of the countryside. The country reminds me of Tazewell County, Virginia, especially the area between Tazewell and Richlands.

"I look forward with a great deal of pleasure to the time of the month when I receive my copy of The West Virginia Medical Journal. I hope that it won't be too long before I can write to you again for a change of address back to Princeton."

* * * *

Major Howard A Swart, of Charleston, who is on the staff of the Newton D. Baker General Hospital, writes that there are about 200 patients in the orthopedic section at this time. "We are getting large numbers of fractures of the femur, tibia, and fibula and other bones," he writes. "Treatment has been started overseas, and we finish it here. They are coming into the hospital in surprisingly good shape."

* * * *

Capt. E. Newton DuPuy, of Beckley, who has been with our armed forces in the campaigns in North Africa, Sicily and Italy, is now assigned to the Crile General Hospital, at Cleveland. Captain DuPuy was awarded the silver star for gallantry in action in the Tunisian campaign.

* * * *

Lieutenant W. C. Boggs, of Wheeling, has been transferred to the Stark General Hospital, at Charleston, South Carolina.

Captain L. B. Matthews, of Charleston, is with the army air force in New Caledonia.

* * * *

Dr. William W. Strange, of Huntington, who is stationed at the Norfolk Naval Hospital, at Portsmouth, Virginia, has been promoted to the rank of Captain.

* * * *

Major Justus C. Pickett, of Morgantown, is assigned to the Regional Station Hospital, Hunter Field, Georgia.

* * * *

Dr. George M. Lyon, of Huntington, who is with our armed forces overseas, has been promoted to the rank of Captain.

* * * *

Captain W. P. Warden, of Charles Town, is now assigned to the 63rd AAA Gun Bn., at Seattle, Washington.

* * * *

Capt. Dan Glassman, who has been stationed at Bowling Green, Virginia, is now assigned to the 230th Station Hospital, A. P. Hill Military Reservation, Fredericksburg, Virginia.

* * * *

Major Athey R. Lutz, of Parkersburg, writes from England that he has been reassigned to the ground force after spending the entire summer and fall of 1943 with the air force. During what he calls "this slack period," he has had an opportunity to visit many outstanding British clinics. "Many courses are offered in anatomy, anesthesia, chest surgery, neurosurgery and war surgery in general," he writes. "Five years' experience has given the British a 'head start' in the latter subject." He states that he has had excellent opportunities to become better acquainted with the British, and that he has seen and talked with several doctors from West Virginia at meetings of the American Medical Association in the European Theater of Operations.

* * * *

Lieutenant Louis H. Nefflen, of Elkins, who was called to active duty in the Army in December, 1943, is assigned to the Station Hospital at Camp Campbell, Kentucky.

WOUNDED RETURN TO ACTIVE DUTY

Forty-one per cent of our U. S. wounded have been returned to active duty. This figure does not include those treated at first aid stations and allowed to return within a few days.—R. N.

County Society News

CABELL COUNTY

Dr. F. B. Peck, of Indianapolis, Indiana, medical advisor on diabetes for the Eli Lilly Company, was the guest speaker at the regular monthly meeting of the Cabell County Medical Society, held at the Hotel Prichard, Huntington, March 9, at 8:30 P. M. His subject was "The Treatment of Diabetes Mellitus by the Single Injection Technique." The paper was illustrated by lantern slides.

COLE D. GENGE, M. D., *Secretary*.

KANAWHA

Dr. Vincent W. Archer, head of the X-ray Department of the University of Virginia Department of Medicine at Charlottesville, was the guest speaker at the regular monthly meeting of Kanawha Medical Society, held at the Daniel Boone Hotel, Charleston, Tuesday, March 14, at 8 P. M. His subject was "Alteration in Gastro-Intestinal X-ray Examination Determined by Symptoms." The paper was discussed by Drs. E. W. Squire and W. Paul Elkin, both of Charleston.

"Wound Healing with Special Reference to Irrigation Technic" was the subject of an interesting paper presented by Dr. R. K. Buford, of Charleston. The paper was illustrated by lantern slides, and was discussed by Dr. J. E. Cannaday.

Dr. Fred Kluth discussed the procedure of treatment of patients at the new Kanawha Valley Medical Center, South Charleston.

Members of an advisory committee to Medical Service, Inc., were appointed as follows: Drs. A. E. Amick, Dan Barber, D. A. Dent, T. G. Reed, and M. I. Mendeloff.

A resolution was adopted accepting the Red Cross plan to pay DPA rates for emergency cases in the families of men in the military service. The members will continue to offer free professional services in cases of absolute need, as determined by the Red Cross.

At the business session which followed the scientific program, new members of the Society were elected as follows: Dr. John T. Jarrett, Dunbar (now in military service); and, Drs. C. Scott McKinley and Joseph P. Seltzer, Charleston.

W. P. ELKIN, M. D., *Secretary*.

MERCER

The regular monthly meeting of the Mercer County Medical Society was held February 17 at the West Virginian Hotel, Bluefield. A round table discussion of obstetrical complications was led by Dr. H. G. Steele, of Bluefield.

FRANK J. HOLROYD, M. D.,
Secretary.

OHIO COUNTY

Official government films showing the method of treatment for and steps being taken to prevent the spread of malaria on the battlefronts and at home were shown by Major Samuel S. Altshuler, M. C., Chief of Medical Service at Fletcher General Hospital, Cambridge, Ohio, at the regular monthly meeting of the Ohio County Medical Society, held in the Solarium at the Ohio Valley General Hospital, Wheeling, March 10, 1944.

The motion pictures were shown in connection with an interesting paper presented by Major Altshuler on the subject of "Tropical Diseases in West Virginia." The speaker stressed the fact that malaria will be brought back home by soldiers and sailors afflicted with the disease, and that it will be necessary for West Virginia doctors to join in the fight to help control it.

Major Altshuler also discussed amoebic and bacillary dysentery with reference to etiology, diagnosis and treatment.

The paper was discussed by Drs. R. J. Snider, H. R. Sauder, D. A. MacGregor, and W. T. McClure.

At the business meeting, the president was authorized to appoint a committee to consider the establishment of a blood bank at the Ohio Valley General Hospital.

* * * *

At a special meeting of the Ohio County Medical Society, held March 17, in the Solarium at the Ohio Valley General Hospital, Wheeling, the following delegates and alternates to the annual meeting of the West Virginia State Medical Association were elected:

Delegates: J. G. Thoner and R. D. Armbrecht (one year), and Ivan Fawcett and M. B. Williams (two years); alternates: S. W. Tretheway, R. J. Snider, J. C. Hazlett, and C. G. McCoy.

ROBT. W. W. PHILLIPS, M. D.,
Secretary.

PARKERSBURG ACADEMY

An interesting address on "Penicillin" was delivered by Dr. James L. Wade at the regular monthly meeting of the Academy of Medicine of Parkersburg, held at St. Joseph Hospital in that city, March 1, 1944. The paper was discussed by Drs. Fred J. Potter, A. R. Sidell and William S. Dick.

W. F. ROGERS, M. D., *Secretary.*

A FABLE—NOT BY AESOP

There was once a farmer who drove 20 miles to the county seat in his pick-up. He drove faster than is recommended by the Government because he had so much business that required his attention. He had to register for the Army, fill out an occupational questionnaire, sign up for crop insurance, get a card permitting him to sell his wheat. He had to go to the court house to put in his application for a tire, to the county superintendent's office for school records to get his eldest child a birth certificate, to the county clerk's office to get a book for tax-exempt tractor gas.

Thinking of all these things confused the farmer so that half way to town he remembered he had to have his war ration books to get canning-sugar permits for his wife; so he went home to get them. When he at last arrived at the court house he found the doors locked and everybody out to lunch, since they were operating on war-time to save electricity. While the farmer was sitting in his pick-up waiting for the offices to open, the State Highway patrolman came along and asked to see his motor-vehicle-tax stamp and his driver's license. Then the chief of police dropped by and asked him to move his pick-up since he was located in a 15-minute parking spot.

So the farmer went to the drug store and bought a box of aspirin and went home and went to bed. And if the Federal Bureau of Investigation hasn't found him, he is probably there yet.—*Rush County (Kansas) News.*

BY GUM!

The stuff that gives a sidewalk cleaner many pains in the back, and many of us an opportunity for some choice language when it adheres to our shoes, can be both a jaw exerciser and a life-saver.

Staff Sgt. Corney Lett parachuted from a Flying Fortress recently onto rural England. The suspicious natives couldn't place his West Virginia accent. To prove his identity, he produced the local equivalent of an American passport—a package of chewing gum.—*New York State Journal of Medicine.*

Obituaries

SAMUEL CECIL AUSTIN, M. D.

Dr. Samuel Cecil Austin, 65, of Charleston, died March 11 in a hospital in that city as the result of injuries received in an automobile accident March 7. He had suffered severe head injuries and a fracture of the leg when the car he was driving collided with a truck.

Dr. Austin was born in Lewisburg, son of the late Dr. Charles N. and Martha (Armstrong) Austin. He received his pre-medical education at West Virginia University and was graduated from the College of Physicians and Surgeons, Baltimore, in 1908.

Funeral services were held at the residence March 12, with the Rev. Wallace M. Alston and the Rev. W. E. Crane officiating. The body was interred in Mountain View Cemetery.

Besides his widow, he is survived by a son, Lieut. Charles N. Austin, who is a prisoner of war in Germany; a daughter, Mrs. Cullen G. Hall, of Charleston; two sisters, Mrs. J. M. Payne and Miss Anne Austin, of Charleston; and, two brothers, Dr. A. L. Austin, of Huntington, and E. L. Austin, of Dallas, Texas.

DAVID BEALE EALY, M. D.

Dr. David Beale Ealy, 55, prominent surgeon of Moundsville, and president of the Marshall County Medical Society, died of a heart attack February 24, 1944, just after returning to his home from a visit in Florida.

Dr. Ealy was born at Schellsburg, Pa., and received his education in the public schools, at Juniata College, Huntington, Pa., and at Maryland Medical College, Baltimore, from which he graduated in 1912 with the degree of M. D.

After practicing at Pulaski, Tennessee, for a few months, Dr. Ealy moved to Moundsville in 1915. He had served as coroner of Marshall county for ten years. He was a member of the American Medical Association, the State Medical Association, and was serving his second term as president of the Marshall County Medical Society at the time of his death. He was a Mason, Shriner, and a member of the Elks, Eagles and Moose. He was surgeon for the Pennsylvania Railroad, and was a member of the Association of Railway Surgeons.

Dr. Ealy served as captain in the medical corps of the A. E. F. during World War I, and was past commander of the Moundsville Post of the American Legion. He had always been active in the civic and political life of his state. He was elected a member of the West Virginia Senate from the second district in 1938, and served during the regular sessions in 1939 and 1941.

He is survived by his wife, Lennis (Irwin) Ealy; a son, Lieut. David L. Ealy (MC), USNR, now stationed at Fort Pierce, Florida; and, a daughter, Mrs. Suzette Ealy Stumpf, of Newark, Delaware.

HORACE L. GOODMAN, M. D.

Dr. Horace L. Goodman, 67, superintendent of the Greenbrier Valley Hospital at Ronceverte, died February 28, 1944, of heart disease. He had been ill for several weeks.

Dr. Goodman was born at Otter River, Campbell County, Virginia, and graduated from the Medical College of Virginia in 1901. He was licensed in West Virginia the following year. He interned at McKendree Hospital No. 2, and was formerly located at McKendree and Thayer, West Virginia. He was a member of the American Medical Association, the West Virginia State Medical Association, and the Greenbrier Valley Medical Society. He was always active in the affairs of the Association, serving as a member of the Council from 1941 to 1944. He had also served as vice president of the State Medical Association and as president of his local society. He was a fellow of the American College of Surgeons, a Mason and a Shriner.

He is survived by a son, Horace L. Goodman, Jr., and a daughter, Mrs. Virginia Goodman Tilton, both of Ronceverte.

FRANKLIN TAYLOR SCANLON, M. D.

Dr. Franklin Taylor Scanlon, 65, of Morgantown, died in a hospital in that city February 25, 1944, after a short illness of mesenteric thrombosis.

Dr. Scanlon was born at Three Trees, near Romney, and received his education at Fairmont Normal (State Teachers) School and the University of Nashville Medical School. He was practicing his profession at Clear Lake, Iowa, at the outbreak of World War I, when he was commissioned a captain in the Army Medical Corps. Following the war, he took postgraduate courses in eye, ear, nose and throat at Chicago Polyclinic and the New York

Postgraduate School. He was licensed in West Virginia in 1922, and located at Morgantown the same year.

He was a member of the Monongalia County Medical Society, the State Medical Association and the American Medical Association, having served as president of his county society and vice president of the state medical association. He was a Mason and a member of the Kiwanis Club of Morgantown, and was always active in the civic affairs of his community.

Funeral services were held February 27 in the First Presbyterian Church, with the Rev. William E. Brooks officiating. The body was interred in the mausoleum at East Oak Grove Cemetery.

He is survived by his widow, Helen (Hardesty) Scanlon; a son, Lieut. F. T. Scanlon, Jr., of the Army Medical Corps; and, a daughter, Mrs. Spencer McCallie, of Chattanooga, Tennessee.

ERRA DELAFIELD STUMP, M. D.

Dr. Erra Delafield Stump, 59, eye, ear, nose and throat specialist, of Charleston, died March 1, 1944, of cerebral hemorrhage.

Dr. Stump graduated from the Medical College of Ohio, Cincinnati, in 1908, and was licensed in West Virginia the same year. He immediately located in Charleston for the practice of his profession. He was a Mason, Shriner, and a member of the Sigma Nu fraternity. He is survived by his wife, Addie (Davis) Stump; his mother, Mrs. Mary Ellen (Copenhaver) Stump; and, a brother, Wilbur Stump, all of Charleston.

DR. HENSHAW NAMED MEDICAL DIRECTOR

Dr. W. T. Henshaw, of Charleston, has been named by Charles L. Heaberlin, state compensation commissioner, as acting medical director for the Workmen's Compensation Fund to succeed Dr. E. F. Gott, who will resume private practice in Charleston.

Dr. Henshaw served for several years as state health commissioner, and has been medical director for Dravo Construction Company since 1933. Work on the Hinton dam, which is being constructed by the Dravo Corporation, has been discontinued temporarily due to the shortage of vital materials.

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OBSTETRICS—Two Weeks Intensive Course starts April 17 and June 26.

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GASTROSCOPY—Personal Course starts April 3, June 19, and October 16.

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Woman's Auxiliary

McDOWELL COUNTY

The regular monthly meeting of the Auxiliary to the McDowell County Medical Society was held at Welch, March 8, with Mrs. C. B. Chapman, Secretary, presiding. The principal address was delivered by Mrs. E. E. Vermillion, of Welch, who spoke on the "History of the Auxiliary." The meeting was attended by nine members of the Auxiliary.

MRS. C. B. CHAPMAN,
Corresponding Secretary.

RALEIGH

The motion picture film, "The Common Defense," was shown at the regular monthly meeting of the Woman's Auxiliary to the Raleigh County Medical Society, held February 21, at the Coca-Cola Building, Beckley. The meeting was attended by fifteen members and seven guests. Refreshments were served. The following members served as hostesses: Mrs. S. A. Ford, Mrs. H. A. Shaffer, Mrs. John W. Bolen, Jr., Mrs. D. B. Jarrell, and Mrs. R. G. Broaddus.

MRS. J. M. CORAM,
Corresponding Secretary.

KANAWHA MEDICAL SOCIETY

The regular monthly meeting of the Woman's Auxiliary to Kanawha Medical Society was held on the evening of February 8th at the home of Mrs. F. A. Clark. Assistant hostesses were: Mrs. T. G. Reed, D. N. Barber, M. I. Mendeloff, R. B. Price, Owen McMillan, U. G. McClure, and R. H. Walker.

During a short business meeting, Mrs. J. E. Rucker, Chairman of the Speakers Bureau, reported that Mr. Charles Lively had been asked to speak before the Woman's Club and Dr. Roy Bird Cook to address the Quota Club, on the subject of socialized medicine.

There were thirty members and four guests present. Mrs. W. E. Hoffman, President, presided.

Doctor's Day was observed by the Kanawha Medical Society Auxiliary on March 14, with a

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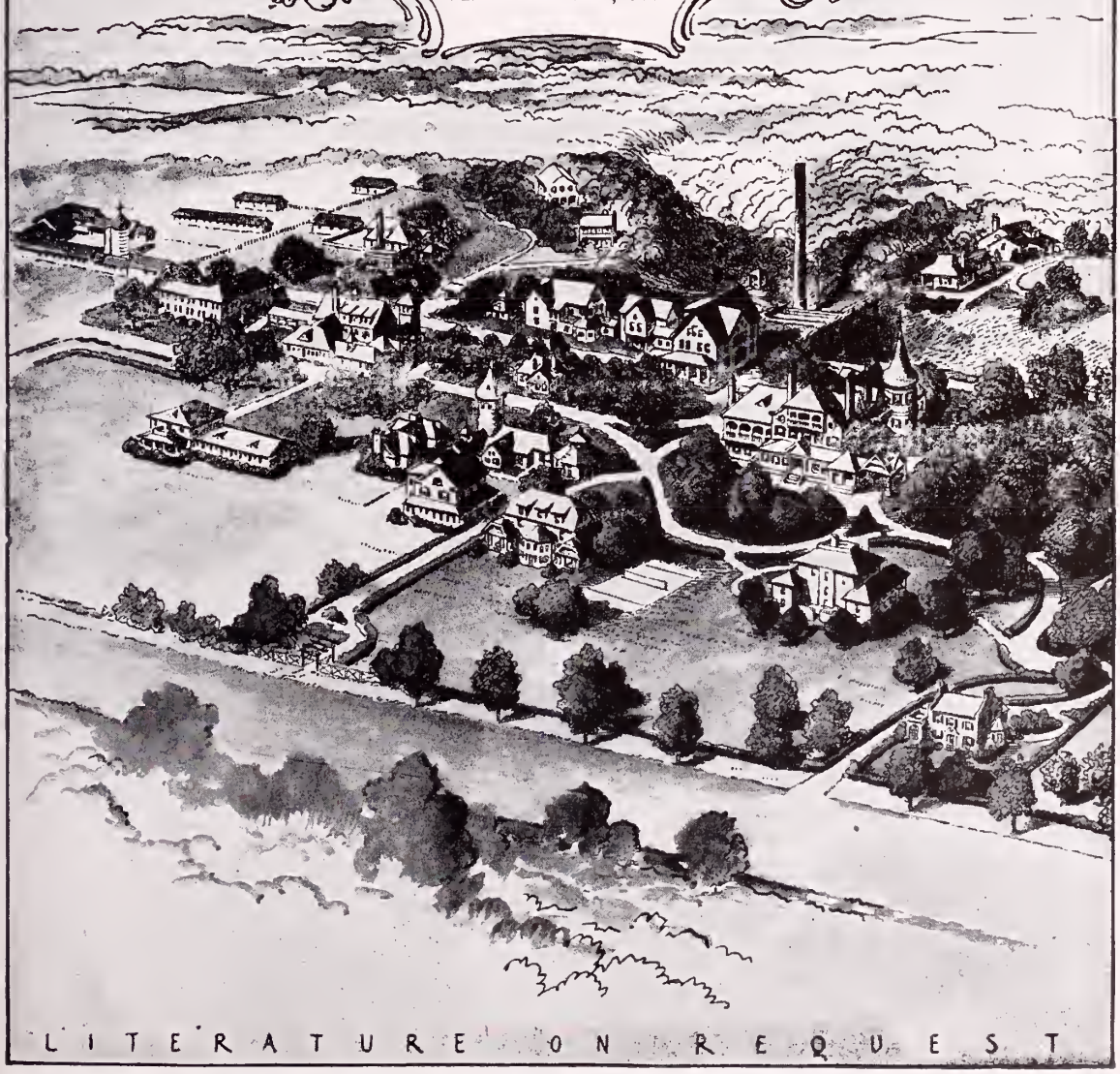

LITERATURE ON REQUEST

luncheon meeting at the Charleston Woman's Club. Mrs. John W. Hash presented a paper on Doctors in the War. Mrs. W. L. Hardesty, assisted by Mrs. L. E. Cox, reported on the local doctors in service, giving their rank, branch of service, and location. A large map of the world was used and flags were attached to show where the doctors are serving.

The members voted to donate $20 from the Auxiliary funds to the Red Cross War Fund.

Mrs. W. E. Hoffman, President, called the meeting to order. There were 37 members and three guests in attendance.

MRS. V. L. PETERSON,
Chairman Press and Publicity.

MUD AND GANGRENE

The mud of Italy increases the incidence of gangrene among soldiers. Men in desert warfare showed only three in each thousand afflicted by this condition, but in Italy the number has been raised to twenty per thousand. Special field laboratories have been set up there to develop more effective serums.—R. N.

SECOND "WAR CONFERENCE"

The Second "War Conference" of industrial physicians, industrial hygienists and industrial nurses will be held in St. Louis, Missouri, May 8-14, 1944, at the Hotel Jefferson. The participating organizations are the American Association of Industrial Physicians and Surgeons, American Industrial Hygiene Association, National Conference of Governmental Industrial Hygienists, and American Association of Industrial Nurses.

This "War Conference" will present an unequalled opportunity for every one interested to any degree in industrial health problems — especially those of present wartime exigencies—to hear them discussed by the recognized experts in all departments of this important and growing field.

HOSPITAL CORPS WAVES

How each of Uncle Sam's Hospital Corps Waves frees a fighting sailor for active sea duty and "helps 100 men" is told and pictured in the March issue of *Hospitals*, the Journal of the American Hospital Association.

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women who have already enlisted in the Corps have had previous experience in hospital or closely allied medical fields, the prime requisite for admission to this group of Waves is the intense desire to "help 100 men" through their humanitarian personal services, according to Lieut. Cmdr. E. G. Dennis (HC), U. S. Navy, author of the article.

"When a hospital Corps Wave releases a corpsman for duty at sea she does so in a complete sense," writes Commander Dennis. "All Waves, before beginning their professional training, receive intensive recruit training which follows closely the pattern of the recruit training designed to make men-o-wars-men."

Keynote of the Corps' recruiting program is this statement to prospective Waves from Rear Admiral Ross T. McIntire, surgeon general of the United States Navy:

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SMA EXECUTIVE COMMITTEE MEETS

A meeting of the executive committee of the Council of the Southern Medical Association will be held in St. Louis, April 4 for the purpose of deciding whether or not a meeting of the Association is to be scheduled for the fall of 1944. The Council went on record at Cincinnati last fall as very definitely favoring a meeting as usual this next fall. Invitations for the 1944 meeting have been extended by the St. Louis Medical Society for the Association to meet in that city, and by the Campbell-Kenton County Medical Society of Kentucky for Cincinnati, Ohio.

AMERICAN BOARD OF OBS. AND GYN.

The general oral and pathology examinations (Part II) of the American Board of Obstetrics and Gynecology, Inc., will be conducted at Pittsburgh, Pa., June 7-13. Formal notice of the exact time of each candidate's examination will be mailed several weeks in advance of the examination dates. Candidates for reexamination in Part II must file written application with the Secretary not later than April 15. Applications are being received for the 1945 examinations. Application blanks and full information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh 6, Pa.

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WARTIME PUBLIC HEALTH CONFERENCE

The Second Wartime Public Health Conference will be held in connection with the 73rd annual business meeting of the American Public Health Association in New York City, October 3-5, 1944. Meetings of related organizations will be held October 2. The scientific program will be devoted to wartime emergency matters as they affect public health.

An optimist sees an opportunity in every calamity; a pessimist sees a calamity in every opportunity.—

STUART McGUIRE LECTURES AT MCV

The 15th annual Stuart McGuire lectures and spring postgraduate clinics will be held at the Medical College of Virginia, Richmond, April 5-6. Dr. Winfred Overholzer, superintendent of St. Elizabeth's Hospital, Washington, and Lt. Col. William Menninger, Chief of the Division of Neuropsychiatry, United States Army, will be the lecturers. Six talks on psychiatric subjects will be given at the clinics by members of the college faculty and others.

NURSING ORGANIZATIONS TO MEET

A joint meeting of the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health

(Continued on page xxxi)

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Nursing will be held at Buffalo, New York, June 5-8. The tentative program provides for business meetings of the ANA and NOPHN and for special conferences of the NLNE. The programs of the National Nursing Council for War Service, the Nurse Education Division of the U. S. Public Health Service, the Procurement and Assignment Service for Nurses, and the American Red Cross Nursing Service will be presented at two joint evening sessions.

TUBERCULOSIS ABSTRACTS

(Continued from page 117)

To determine whether a demonstrable lesion is tuberculous one must seek tubercle bacilli in material obtained from it. Among individuals with extensive tuberculous lesions these are usually promptly recovered from the sputum. When bacilli are not found in more than one of several specimens, or if no sputum is present, gastric lavage may reveal their presence. Visualizing acid-fast organisms by the aid of the microscope may not be sufficient because of laboratory errors and also because non-pathogenic, acid-fast bacilli are sometimes found in the sputum and gastric contents; therefore, their pathogenicity should be determined by culture on artificial medium or by animal inoculation. In the event tubercle bacilli or other pathogenic organisms are not recovered, one should observe frequently new x-ray films to determine whether abnormal shadows persist or any significant changes occur in or around them. However, among persons beyond thirty-five years one should avoid delay, as the lesion may be malignant. In such cases the bronchoscopist should be consulted, as he may promptly reveal the etiology.

There is no more deplorable practice than to have tuberculin tests administered and x-ray films prepared, after which the physician makes diagnoses without seeing the subject and completing the examination. The individual should always be interviewed by the physician. While most persons have no symptoms for an average of two to three years after the disease can be located and practically none of those with primary tuberculosis give histories of significant illness, the tuberculin reactors whose chest films are entirely clear may relate symptoms caused by extra-thoracic tuberculosis.

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Advertising space in the Directory of Physicians in Limited Practice may be had by communicating with Mr. Charles Lively, Business Manager of the West Virginia Medical Journal, Box 1031, Charleston 24, W. Va. The cost is one dollar per month. Space may be had only by members of the West Virginia State Medical Association.

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Vol. XXXX May, 1944 No. 5

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By J. LOUIS NEFF
New York, N. Y.

Cancer is probably the most personal of all the diseases which are thought of as public health problems, and which attract the attention of public health departments. It is neither contagious nor infectious and therefore presents no epidemic hazard; it is not transmitted by direct inheritance; it cannot be prevented by any form of vaccination now known or other wholesale preventive measure; it cannot be detected by mass surveys such as are available in the field of tuberculosis controls. Hence, to the epidemiologist it offers little but an opportunity for statistical study.

Yet cancer is the second leading cause of death. Each year it kills from 150 to 170 thousand people in the United States. It is the leading cause of death among women in the age group of 35 to 54 in spite of the fact that many forms of cancer can be cured in a high percentage of cases, and many forms can be prevented. So, although cancer does not fit into the general pattern of the type of disease or condition which is usually thought of as a problem for the public health authorities, it constitutes a major health problem and it is a disease which is becoming more and more a matter of concern to the official health agencies as well as to the practicing physicians. The creation of a Division of Cancer Control in the State Department of Health is a step of which West Virginia may well be proud.

Cancer is a personal problem because in perhaps no other curable disease is the cure so dependent upon an intelligent and enlightened attitude on the part of the patient. The symptoms of early cancer usually are observable only by the patient himself. Pain is commonly a late symptom so there is nothing to drive the patient to seek medical care at an early stage of the disease except a knowledge of the nature and significance of certain apparently trivial signs and symptoms, each

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*Presented before the Fifth State Assembly of the West Virginia Division of the Women's Field Army of the American Society for the Control of Cancer, Charleston, West Virginia, March 2, 1944.

of which might also indicate any one of a number of conditions of less importance.

Cancer is also a personal problem because few diseases depend for their cure upon such a high degree of intelligent cooperation between the patient, the physician whom the patient first consults and the surgeon, the roentgenologist, the pathologist, or other specialist who must make the final diagnosis and institute the appropriate treatment. Early cancer is highly curable; late cancer presents a pretty hopeless picture. Delay in diagnosis or in the starting of treatment is fatal and it makes little difference whether the delay is caused by the failure of the patient to report early symptoms, or by the failure on the part of the physician first consulted to recognize the potential importance of those symptoms, or by the inability of the patient to secure the early diagnostic services and treatment suggested by his physician.

It thus becomes obvious that the cure of cancer depends upon three factors: first, an informed public which is aware of the importance of the early investigation of significant signs and symptoms; second, an enlightened medical profession alert to the possibility of cancer being the explanation of obscure and apparently trivial symptoms, courageous enough to demand further investigation of the unexplained symptom, and optimistic enough to realize that early cancer can be cured. The third factor is the immediate availability of the necessary diagnostic and treatment facilities—pathological, x-ray and other examinations; radium, high voltage x-ray, surgery, and hospital accommodations.

DIAGNOSTIC AND TREATMENT FACILITIES

The American Society for the Control of Cancer, since its organization in 1913, has always been interested in these three factors. It saw that the first requirement for the success of its program is the availability of diagnostic and treatment facilities and a medical profession which is skilled in their use and prepared to make these benefits available to the cancer patient in an early stage of his disease. Accordingly, in 1927, the Society started the movement which has developed into the program of approved cancer clinics under the administration of the American College of Surgeons. The first list of "approved clinics" was published in 1933 and included 140 institutions. The 1943 list covers 392 cancer clinics, cancer divisions and special cancer hospitals of which all but about 25 are within continental United States.

APPROVED CANCER CLINICS

When this program of approved cancer clinics had developed to the point where skilled medical attention was reasonably available in all parts of the United States, the Society turned its attention to the problem of inducing the public to accept what the medical profession was prepared to make available, and to seek this medical care early enough in the progress of the disease to assure reasonable hope of cure.

This, obviously, was a matter of education. Because cancer is such an intensely personal problem, it was decided that the educational efforts necessary for its control could best be conducted with the assistance of volunteer women who would bring to the work the enthusiasm, the patience, the sympathy and the intimate personal contacts which would be necessary to break down the fear, the horror and the tabu which so long have been associated with this disease. To secure this reservoir of assistance, the Society, in 1935, organized the Women's Field Army, and started its campaign to enlist the services of the leaders of women in every community. It was not planned that these women should become "experts" either in the diagnosis or the treatment of cancer. It was not intended that they sit down either with their friends or with strangers and discuss symptoms or prescribe treatment. Their job was to tell everyone who would listen that early cancer can be cured, that certain signs and symptoms might mean cancer, and that the discovery of any of these signs should be followed by an immediate visit to a competent physician for a careful study to make certain that cancer was not present or threatened.

As the work of the Field Army progressed it soon became evident that the education of the public was not enough. Provision must be made for the care of the people who have been reached by the educational efforts. Diagnostic and treatment facilities still presented grave problems in many states. The availability of such facilities to the indigent and to those of the borderline economic groups is essential to any cancer control program. Hence, the Women's Field Army was encouraged to assist the local medical profession and the public authorities in solving these problems on the basis of the local needs and local opportunities.

ORGANIZATION OF FIELD ARMY

Since the cancer message and the cancer control efforts must be personal and extend into the individual home, the organization of the Field Army must be based upon the local community. Since the county is usually the smallest workable unit, the purpose of this paper is to outline a plan for the local solution of local problems by the organization of county units. These local problems vary greatly with local conditions and for this reason the plan for their solution must be broad and flexible and deal more with generalities than with specific recommendations.

Assuming that the local commander has been selected on the basis of leadership and organizing ability, knowledge of local people and conditions, enthusiasm and the ability to do a lot of hard work under what may prove discouraging conditions, the first step in starting the program is a number one "must": Secure the advice, guidance and complete cooperation of the local medical profession. It must be understood that this "advice, guidance and complete cooperation" goes a long way beyond a mere passive approval of the idea, or a list of speakers to be called upon to address meetings, and the "local medical profession" means a great deal more than the selection of one or two doctors to help out merely on the basis of personal friendship. The county medical society is interested in this problem of cancer and we should seek its official participation in every step of the way, including the formation of the preliminary plans. Usually the president of the society will refer the matter to a standing committee. Perhaps the most effective procedure would be the appointment of a Cancer Committee composed of doctors having special experience and interest in this field.

The second "must" in organizing a county for cancer control is to find out what are the major local problems, the major local needs, and the present or potential local resources. This is a task which must, of course, be shared with the medical society. After we have surveyed our local situation we can set up a long-range program, and then comes the third "must": Don't try to do too much; don't try to do it all at once; put first things first and be content to take one step at a time. To this might be added another thought: You can't do it all yourself so get as many as possible to help you.

This help can be secured from individuals, of course, but help will also be available from organized groups. The health officer and public health nurses, the dental society, the official and voluntary welfare and social work organizations, all will join the medical society in giving advice and assistance. Librarians, high school science teachers, ministers, hospital executives, the Red Cross, the American Legion and other veterans' organizations, newspaper publishers, radio station operators, all are interested in the welfare of the community and the prevention of needless deaths.

EDUCATION

With this as a background, let us examine the job to be done. Since the cure of cancer depends upon an informed public as well as an enlightened medical profession and the availability of diagnostic and treatment facilities, the primary job of the Women's Field Army is education; in most communities the secondary job is service.

The need for education on the subject of cancer is universal; it extends into all walks of life, all corners of the community. But let

me hasten to point out and to emphasize that in the program of education there must be a division of labor. The lay members of the Field Army, for example, are not going to attempt to educate the medical profession. That is a job for the medical men themselves through their state and county medical societies. Similarly, when the time comes to educate school children, the job is one for the school authorities and the professional educators. The Field Army's rôle in the program is to educate the general public with the help of the professional groups, and to encourage the professional groups to initiate and conduct their own programs.

EARLY MEDICAL ADVICE

For a cancer control program to reach its maximum of possibility for good, these several educational efforts must proceed hand in hand. Obviously, it is of small value to encourage the potential cancer patient to seek early medical advice if the physician he consults is not prepared to meet him halfway. The physician must be willing to give the patient a sympathetic hearing, take a comprehensive history, make an adequate examination, and refer the patient to an appropriate source of further investigation if all the reported symptoms are not completely explained. The physician must not ascribe the patient's intelligent concern over vague danger signals to "hysteria", "hypochondria", or a "cancer phobia." The person whose symptoms are not due to cancer must of course be reassured, but he must not be dismissed until the physician himself is honestly assured that the possibility of cancer has been completely ruled out. Early cancer usually presents vague and inconclusive symptoms which can mean any one of a number of things. If we are to discover cancer at a stage when it can be cured, the Field Army must teach the public to insist on a complete explanation of these vague symptoms. The medical profession should be equally anxious for a satisfactory explanation.

For a proper correlation of the public and the professional phases of the educational program we must depend entirely upon the services of our medical advisors. The Field Army can undoubtedly help in many ways. Perhaps funds can be provided to enable the medical society to secure out-of-town speakers or the loan of scientific exhibits; perhaps the medical society has a monthly bulletin which needs financial assistance in return for which it would publish cancer articles; perhaps the doctors would like to distribute reprints of important scientific papers; possibly local doctors could be given "fellowships" to permit them to leave home for a period of postgraduate study at some cancer teaching center. But whether the Field Army can help, or how it can help is a matter for determination by the medical men themselves.

Remember that there are three vital factors in the cure of the cancer patient: an informed public, an alert and enlightened medical profession, and the availability of diagnostic and treatment facilities. Assuming that the educational program is well under way, let us turn for a moment to the service features of the program. The best of cooperation between the patient and his physician is of small value unless facilities are available to provide the necessary diagnostic procedures and the x-ray, radium, surgery and hospital care which are needed.

CARE OF INDIGENT SICK

This brings us into a more delicate problem and one in which the solution depends entirely upon local conditions, local policies and local attitudes. The care of the indigent sick is coming more and more to be recognized as a responsibility of the community through its organized governmental activities. If adequate local facilities are not available for the diagnosis and care of the indigent cancer patient they must, of course, be provided. In general, however, it will be found more appropriate for the Field Army to expend its energies in helping to secure these facilities rather than in attempting to provide them by paying the bills of individual patients. Limited funds are soon dissipated in this fashion and probably would be of greater

service to the community if expended in educational activities.

There are occasions when this general policy must be changed. Sometimes public facilities are available at a distant point and the problem is one of transportation of the patient. Here the Field Army should seek the assistance of other agencies, either those already engaged in similar activities, as for example the motor corps of the Red Cross, or those having a logical interest in such problems, such as the business men's service clubs, the veterans' organizations, church groups, or voluntary welfare and social service agencies.

The ideal solution of this transportation problem is probably an appropriation of public funds to supplement the funds appropriated for the support of the treatment facility to which the patient needs transportation. The payment of such expenses, if undertaken at all by a voluntary agency such as the Field Army, should preferably be on a "demonstration" basis, with the responsibility being taken over by the appropriate authorities as soon as the merit of the program has been demonstrated by a period of trial. Meanwhile, the indigent cancer patient has to be taken care of, and the method can be worked out only by a knowledge of local conditions.

SERVICE PROGRAMS

There are a few Field Army service programs which are entirely appropriate for as long as the need exists. In many communities members of the Field Army render valuable service in the hospitals as assistants in the office, clinic, record room, social service department, diet kitchen and elsewhere. This is not to be confused with the Volunteer Nurse's Aide program of the American Red Cross which trains women to assist in the actual care of the patients, but the service of these less technically trained volunteers can be made a very valuable contribution to the wartime economy of the community hospital.

Another project which has very large possibilities is the collection of old linen and the preparation of dressings to be distributed by public health nurses or the social service department of the hospital for the use of cancer patients under care in their own homes.

It is not the purpose of this paper to describe how these projects can be organized and conducted. Neither is there time to describe the technic of public education or the newer plan of introducing the subject of cancer control into the science classes of high schools. Complete information on these subjects is available to those interested. For the present it is sufficient to say that a well organized Women's Field Army can make a real contribution to any community in its efforts to prevent suffering and promote the health of its people.

It is conservatively estimated that if it were possible to bring to bear on every case of cancer the full sum of our present diagnostic and treatment knowledge as soon as the patient is first aware of warning symptoms, we might expect to prevent from one-third to one-half of the annual deaths from this disease. In 1941 the State of West Virginia reported a total of 1,546 deaths from cancer. The possibility of prolonging the lives of 773 residents of this state presents a prospect which cannot fail to interest the medical profession, and the leaders of the social, civic and political groups, fully as much as it does the State Department of Health and the group of earnest and determined women which constitutes the West Virginia Division of the Women's Field Army. I bespeak for them the full measure of support and assistance which the importance of their work so amply justifies.

To borrow a slogan: "Let Us Serve and Save the Cancer Patient."

A. M. A. AT CHICAGO JUNE 12-16

The annual meeting of the American Medical Association will be held at Chicago, June 12-16. Headquarters will be established at the Palmer House, where all scientific sessions will be held. Commercial exhibits will be set up in the newly reopened Stevens Hotel.

A FLOCCULATION TEST FOR SYPHILIS

By W. L. HARDESTY, M. D.
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THE purpose of this paper is to describe concisely a serologic test for syphilis characterized by simplicity, rapidity of performance and, it would seem, reliability.

Over a decade ago, Jurischk[1] and I showed that serum for the Kahn test may be heated for a very brief period at a temperature higher than the conventional 56° C. Largely because of this practice, the test here described may be completed within twenty minutes after the serum is obtained.

Only in a relative sense may the method be regarded as new. In this respect it is like every other flocculation test for syphilis; all depend upon the fact that when syphilitic fluid (e.g., serum) is brought in contact, under appropriate conditions, with certain lipoidal extracts (antigens), visible floccules are formed.

Any serologist will readily perceive that in one respect or another the technic here presented resembles that of Eagle, Hinton, Kline, or especially that of Kahn. Each of these methods has great value, and in each are traces of methods previously devised.

The choice of technic depends largely upon the personal inclination of the serologist and the special reasons for which the test is performed. For example, when early or very late syphilis is in question, a sensitive test is most helpful; for transfusion or where many individuals are to be examined, simplicity and speed are important.

SCIENTIFIC BASIS OF TECHNIC

The technic has been evolved chiefly from experiments conducted in the past five years, during which the writer has investigated the principal variables of syphilis flocculation reactions (antigen, serum, time, temperature, agitation and other factors). The possible variations and combinations of these are almost appalling. Even to summarize the experiments in a non-technical journal would lead us too far afield; hence we shall proceed at once to a brief description of the test.

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APPARATUS AND REAGENTS

1. Apparatus: Any laboratory equipped for the Kahn technic will require no further apparatus except a "dissecting microscope." This inexpensive device, familiar to students of biology, consists essentially of a convex lens fixed upon a pivot which permits accurate focusing over a small pane of ordinary glass, upon which at least three tubes (e.g., positive control, negative control, unknown) may be viewed simultaneously and conveniently. Light, either daylight or artificial, is reflected upward from a slanting mirror. The apparatus is compactly mounted in a small box. Once its use is mastered, this instrument renders an astonishing amount of aid in distinguishing between doubtful and positive reactions.

2. Reagents: (a) 0.9 per cent saline made from NaCl, C.P. This must be neutral in reaction, and clear.

(b) Antigen* is prepared under conditions of aridity (low relative humidity). Thus the extraction of water-soluble impurities, against which Kline[2] and Levy[3] have warned, is to a great extent avoided.

Extract 100 grams beef heart powder (e.g., "Difco") with 400 cc. anesthetic ether,

*Any colleague desiring to prepare this antigen may correspond with the author for more detailed information, including helpful technical suggestions omitted here.

shaking for ten minutes. Allow the powder to settle. Carefully pour off the ether by successive decantations, retaining as much as possible of the powder in the flask (cf. Hinton).[4] Do not retrieve the small quantities of heart powder and waxy impurities decanted with the ether. Extract likewise three more times. Rinse briefly with a little ether, decant this and spread the moist powder to dry in an arid atmosphere (bacteriologic incubator if necessary).

To the dried powder add 500 cc. alcohol, preferably absolute, shake thoroughly for ten minutes and allow to stand, well covered, for three or four days, with occasional shaking. Filter by decantation; rinse the powder with two or three small portions of alcohol, adding the rinsings to the filtrate until the total volume is about 400 cc. (cf. Eagle).[5]

Fortify the alcoholic extract with C.P. cholesterol, 0.6 gm. for each 100 cc. Dissolve by rotating the flask in a pan of warm water. Filter and allow to stand several days in a dark place at room temperature.

Titrate against 0.9 per cent saline as for Kahn antigen, examining the tubes with the dissecting microscope. The titre is usually between 1.2 cc. and 1.6 cc. saline to 1.0 cc. antigen.

Of course the antigen must be tested against several syphilitic and several non-syphilitic sera.

(c) Serum must be free from erythrocytes and other particles, but moderate hemolysis is not harmful. It is heated in the water bath at 60° C. for five minutes. Two to three minutes will suffice if the serum has been previously heated.

METHOD

(1) Set up one small tube for each serum to be tested.

(2) Pour (dump!) the required quantity of saline into 1.0 cc. antigen and mix by pouring swiftly back and forth, as in the Kahn technic. Allow the resulting emulsion to stand for ten minutes. During this period the sera may be heated.

(3) Thoroughly mix the emulsion and place 0.025 cc. in a small tube. Controls (negative and positive) must be set up.

(4) To each tube add 0.15 cc. heated serum. Thus the antigen-serum ratio is 1:6. The absolute quantities recommended here have been chosen because they are those employed in the middle tube of the Kahn test, with which almost every technician is familiar.

(5) Shake by hand for a few seconds. Time permitting, allow the rack to stand about five minutes. Now shake by machine three to four minutes.

(6) To facilitate reading, place about 0.5 cc. saline in each tube. Examine with the aid of the dissecting microscope. The optimum focus may be determined by viewing the floccules in a known positive serum or bubbles produced by flipping the tubes.

Negative Result: The fluid is uniformly opalescent. On agitation one may sometimes observe a smoky swirl of tiny scintillating particles, rather like those in the Eagle test.[6]

Positive Result: Suspended in a more or less clear fluid are definite granules, suggestive of corn meal, sleet or compact snowflakes.

Doubtful Result: The particles are numerous and fine (dust-like). Such reactions frequently can be resolved by a 2-tube supplementary test, like the routine procedure, except that a larger and a smaller amount of antigen emulsion are employed, as follows:

Tube No.	Antigen Emulsion	Serum	Antigen—Serum Ratio
1	.05 cc.	0.15 cc.	1:3
(2)	(already done in routine)		(1:6)
3	.015 cc.	0.15 cc.	1:10

If at this time tube No. 1 or No. 3 gives a definitely positive result, the report is positive. The readings are never averaged. Other possible results are:

Tube No. 1. Doubtful.
Tube No. 3: Negative or doubtful.
Report: Doubtful; suggest quantitative test.

Tube No. 1: Negative.
Tube No. 3: Doubtful.
Report: Doubtful.

PSEUDOQUANTITATION

Results with this qualitative test should be reported simply as positive, doubtful or nega-

tive. It is becoming generally recognized that plus signs are not only meaningless but often misleading and harmful.

QUANTITATIVE TEST

The heated serum is diluted thus: 1 in 1 (whole serum), 1 in 5, 1 in 10, 1 in 20, 1 in 40, 1 in 80. Each dilution is tested as in the qualitative procedure.

If, for example, 1:20 be the highest dilution which gives a positive reaction, the report is "positive in dilution of 1 in 20."

RESULTS WITH THIS METHOD

Because of its pristine excellence and worldwide reputation, the Kahn test has been employed as a standard of comparison. Regardless, however, of serologic findings, no serum is listed as being either syphilitic or nonsyphilitic without good clinical reason.

TABLE NO. 1—NON-SYPHILITIC SERA (362 TESTS)

Technic	True Negatives	False Doubtfuls	False Positives	Specificity Per Cent
Kahn Standard	362	None	None	100%
H*	362	None	None	100%

*H designates the technic described in this article.

TABLE NO. 2—SYPHILITIC SERA (307 TESTS)

Technic	True Positives	True Doubtfuls	False Negatives	Syphilis Detected,%
Kahn Standard	173	54	80	73.9%
H	224	28	55	82.0%

More than half of the syphilitic sera were from treated cases.

From table No. 1 we see that both tests have been 100 per cent specific (free from false doubtful or positive results). From table No. 2 it appears that the newer technic is rather more sensitive than the Kahn test. It is, of course, too early to form a final opinion. Such must rest not upon results with mere hundreds but with many thousands of sera.

The writer hopes that other workers will try this method and inform him of any difficulties or suggestions concerning improvement, for the test is by no means offered as perfect and immutable.

SUMMARY

1. A simple and rapid flocculation test for syphilis has been described.

2. Of 362 tests on sera presumably nonsyphilitic, 100 per cent have yielded negative results.

3. The results with 307 syphilitic sera, many from treated cases, have been 224 positive and 28 doubtful, the total sensitivity thus being 82.0 per cent.

ACKNOWLEDGMENTS

For aid in the research upon which this technic is based, the writer is grateful to the authorities and personnel of Staats, McMillan, Saint Francis and Kanawha Valley hospitals; to Miss Katherine E. Cox and Mr. Walter M. Bowman, State Hygienic Laboratory; Dr. Herbert Wise, and Drs. Fred C. Kluth and Harry M. Mican of the county and city health departments (Venereal Disease Control Division).

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NEED FOR OCCUPATIONAL THERAPY

Thousands of men will face a post-war future maimed in body and mind. Just how large the toll of manpower will be is anybody's guess.

But figures recently released show that because of mental illness the armed forces discharge 25,000 men a month, and because of other medical disabilities 45,000 additional men are released monthly. The much talked about second front is expected to increase the casualties many times.

While we are in the midst of war it seems easy to promise that veterans handicapped as a result of service to their country will never lack for jobs. But the truth is that these men may be called upon to show a second and perhaps larger heroism in becoming adjusted in the civilian world.

Because the need will be greater than can be met by the Veterans' Administration, the National Committee for Mental Hygiene has formed a Rehabilitation Division to see that adequate care is provided for all these men.—*Harvie DeJ. Coghill, M. D., in Virginia Medical Monthly.*

APPRAISAL OF PUBLIC RELATIONS PROGRAMS FOR THE MEDICAL PROFESSION IN AMERICA*

By EDWARD H. SKINNER, M. D.
Kansas City, Missouri

At the 18th National Conference on Medical Service held in Chicago, February 13, 1944, there were four expositions of programs promoted by organizations in local or regional areas which have ambitions to perform public relations for American medicine. Mr. Roland Watterson discussed the plans of the Lake County (Indiana) Medical Society which have been exposed in an eight page newspaper-type broadside that has been mailed to many physicians. Dr. Michael A. Tighe, secretary of the Massachusetts Medical Society, presented proposals of six New England medical societies in a modest document proposing alternatives to the Wagner-Murray Senate Bill No. 1161. Mr. Ben H. Read, executive secretary of the Public Health League of California, offered evidence that eleven western states had formed The Western Health League and proposed the establishment of a national health league to be financed by a contribution or assessment of one dollar from each of the members of the state medical societies. Dr. L. H. Bauer, chairman of the Council on Medical Care and Public Relations of the American Medical Association, reported the progress of that Council. The writer presented the over-all picture of the stimulating program of the National Physicians' Committee for the Extension of Medical Service under the title as given at the beginning of this paper. He used 20 posters, now available upon lantern slides, that illustrated the several activities of the N.P.C.

With no intent of disparaging but rather to compliment the several projects, both regional and local, whose aim is to promote a better appreciation by the public of the medical profession and to erect a majority public opinion against governmental or compulsory health insurance, it is proposed to offer concrete evidence of the extent of publicity and public relations activities originating within the National Physicians' Committee for the Extension of Medical Service.

THE AUTHOR

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The publicity and propaganda have two primary motives. First, to show the American people that, in spite of all the alleged faults of American medicine, there is no country upon the face of the earth that enjoys such wide distribution of medical service, sustains such a low death rate and maintains such a minimum of infectious diseases. Secondly, that in order to justify the second half of its name, the N.P.C. has purchased from reliable and expert sources, surveys of "The Public's Viewpoint on Medical Care." This country's opinion has been sampled in all sections by the best methods that modern social science has developed. Further, the N.P.C. has purchased from the same expert sources surveys of methods of providing medical and surgical care by many methods of prepayment, postpayment, company payment, straight insurance, etc. These surveys carry the mass opinion of both those who receive such care, (the patients), and those who deliver these services, (the physicians of each community).

*Published concurrently with the Kansas City Medical Journal.

These surveys have been placed in the hands of the Council on Medical Care and Public Relations of the A.M.A. You will shortly hear much about these valuable documents.

The activities of the N.P.C. now cover a period of nearly four years and date from the first battle against the original Wagner Health Bill. Not a single activity of the committee is motivated by partisan origin or ambition. Every trustee is a member of the A.M.A. and most of them have held elected positions somewhere therein. There is complete agreement by the committee on the principles of the A.M.A. as they have originated in the House of Delegates. All funds of the committee, their origins and disposals, enjoy constant survey by a public accountant and this is available to any subscriber, any physician or any citizen.

The extent of the committee's activities is prodigious over these four years. Certain activity has been continuous and of indirect value but definite in purpose and well planned. These activities enjoy expert origins and supervision. They are controlled by physicians who are wise enough to insist that public relations and publicity require professional experts of wide experience who enjoy the confidence of their competitors. Such publicity experts must have the medical viewpoint. The ethical standards of American medicine must not be jeopardized or invaded. The physician-trustees feel that it is their duty to help originate, guide and advise, to secure medical and professional cooperation and, above all, to maintain the standards erected by the House of Delegates throughout the years.

TECHNICS

Just as medicine has devised new methods, new technics and new specialties, in a constant and devotional spirit of progress, so has there been a paralleling development and constant improvement in the technics and methods of public relations. Medical minds of talent and eminence attest to this and vouch for the sanity and practicability of physicians seeking and securing public relations counsel worthy of the problems involved. These problems go far beyond the education and experience of physicians who are practicing medicine.

This is no time for a rehearsal of the committee's four years of activity, but rather, is it a time to describe its program since June, 1943, when the Wagner-Murray Senate Bill No. 1161 was introduced into the Congressional hopper. Less than one year! But what an exciting period!

COUNCIL ON MEDICAL SERVICE

In this same June, 1943, the House of Delegates met in Chicago. Out of the several ambitions to reorganize, stimulate or erect new public relations attitudes and bureau activities, there was created by compromise a Council on Medical Service and Public Relations that covered the field of two bureaus which have been in existence for years. As yet, this new Council does not control either bureau, but each bureau advises and cooperates with the new Council. As yet, it has not been demonstrated that the two bureaus have been yoked to the Council. Rather, would it appear that the Council was straddling a span of bureaus of known integrity but unknown speed. Be that as it may, the new Council is guaranteed 100 per cent when one analyzes its personnel and its ambitions.

The Wagner-Murray Senate Bill No. 1161 was introduced the week before the creation of the Council. There is no record of any discussion of the Bill by officers, delegates or bureaus during the meeting of the House of Delegates. What was the date of the first discussion of the Bill in the *Journal of the A.M.A.?* When were the first editorials published? What was the date of the first statement by the new Council? These dates are a matter of record in the pages of the *Journal*. They are all good statements. Their timing depended upon innumerable factors. The impatience of many of us was probably not justified, but the apparent delay irked.

I propose to tell you what happened in this period from June to November, 1943,

that crystallized activity among physicians throughout the country. Never before has there been such an avalanche of printed matter against a given piece of legislation and in support of better medical practice. Medical journals followed the first publication by the N.P.C. of an analytical pamphlet with pages of original and paraphrased publicity. Lay editorials sprang from every leading newspaper in the country. County and state bulletins burst forth as never before in the history of medical public relations. Service clubs, chambers of commerce, lodges, churches, etc., were stimulated by physician members to hear the story of American medicine, to support physicians in their ambitions and projects to improve medical practice—and all this without indulging in the centralization of medical services through compulsory health insurance or any breed thereof.

It has been conceded by public relations experts from all parts of the country that the wave of publicity in favor of private enterprise in medicine and of maintaining the autonomy and integrity of the medical profession has no comparable example in this or any other field of publicity. Furthermore, there is incontestable proof of the effectiveness of this publicity in favor of the medical profession. This proof is contained in the recently published surveys of "The Public's Viewpoint on Medical Care" of which you will hear much, probably before you read this article.

There is no attempt to arrogate to the N.P.C. any more credit than the profession is willing unbegrudgingly to grant. The major credit belongs to the rank and file of the profession who took the material and accomplished so much in their individual and collective propaganda efforts. What a flood of local and regional support developed almost overnight! What a magnificent demonstration of the ability of the profession to do a necessary job! What a job the editors of medical journals and newspapers did almost spontaneously without knowing just how this wave of publicity developed!

Briefly, the record of this publicity program is as follows:

1. By July 1, 1943 the pamphlet, "Abolishing Medical Practice", had been constructed, printed and sent to all physicians in the United States and to 750,000 other professional and business men.

2. One hundred and thirty-two thousand physicians were asked to write to their senators for a copy of the Wagner-Murray Senate Bill No. 1161, so that they could read and study this Bill which would change their status from that of a professional servant to that of departmental slave of the government. We know that thousands did this and that the document room of the Senate was exhausted of copies of the Bill. Dr. Hall of Hutchison, Kansas, has the letter from Senator Capper acknowledging this fact.

3. An eight-page abstract of the pamphlet, "Abolishing Medical Practice", was printed for distribution generally to the public. It was changed in form as soon as the first Ding cartoon appeared. This cartoon was a better and briefer argument than the printed word. A second Ding cartoon appeared in November. It is unofficial that there will be more from this penetrating, popular artist. This emphasis upon nationally distributed cartoons is not intended to detract from the immeasurable importance of innumerable local cartoons.

This now-famous eight-page abstract headed "3,048,000.00", has to date had the tremendous distribution of 15,000,000 copies. This spread throughout the whole United States has been through national drug manufacturers, national chain drug stores, national retail grocers, National Small Business Men, American Bar Association, insurance companies, American Dental Association, and veterinarians. It is assured that at least 16,000,000 copies of this convincing abstract will be placed in the hands of heads of families throughout the forty-eight states.

4. Newspaper mats of the Ding cartoons and mats for a full-page newspaper display of the eight-page abstract were, and continue to be, offered to all daily newspapers in America and to all secretaries of the 1,900 county medical societies. Up to February 1, 1944, there had been more than 161 of the full-page mats printed and more than 300 cartoon mats requested. The N.P.C. pays for the mats and stirs up the editors and secretaries to accept them. Their local printing is gratuitous or paid by collections from the local physicians, drug-

gists and citizens. It is simple to estimate that this widely distributed and eagerly read material would have cost more than $1,000,000 if bought and paid for through an advertising agency.

5. The N.P.C. has made several mailings of material for publication, editorials and speeches to the secretaries of the 1,900 county medical societies, editors of medical journals and all editors of daily newspapers. These stimulated talks by doctors to service clubs, commercial bodies, churches, lodges, etc. It produced a flood of editorials and newspaper stories.

6. Unexpected publicity which has been of great value has been printed in the left-wing newspaper, "PM", of New York City and the anti-A.M.A. quarterly, "Medical Care." Some of our copy has been reprinted. Both of these several page spreads have been of more value to American medicine than the editors of these sheets really intended. Such attention from such sources is complimentary and a frank acknowledgment of the effectiveness of our publicity efforts.

7. Hofer editorials to country newspapers. For three years brief editorials acceptable to the editors of 12,000 weekly newspapers throughout the United States have carried propaganda for the American physician and against governmental medicine. We know that about 3,000 per month are printed and read by American voters.

So much for the several items of publicity that fanned the flames of opposition of the Wagner-Murray Senate Bill No. 1161.

Before reciting briefly the constructive program for the extension of medical service, one must call attention to the pre-election poll of all candidates for Congressman or Senator in the 1942 election. This was a job in public relations done by the N.P.C. that anticipated the introduction of such legislation as we are now fighting. It was a non-partisan effort to educate all candidates for our national Congress in the principles of medical practice as outlined by the House of Delegates of the A.M.A. It was gloriously successful. A majority of those elected favored the position of the A.M.A. This poll has been used to telling advantage by the Association's leaders in the Washington scene. This poll was expensive and was entirely financed by the N.P.C. It would have cost ten times as much after election, and it would not have been worth as much.

As a concluding statement of the ambitions of the N.P.C. to carry through with the second half of its name, this outline of policy and the practical avenues of solution are lifted from the announcement of the meeting to be held in New York on March 8, 1944 with leaders of medicine, industry, insurance and drug manufacturers:

The Board of Trustees of the National Physicians' Committee, at the annual meeting in Chicago, November 20-21, 1943, adopted the following resolution:

WHEREAS, the preservation of the principles fundamental to maintaining the quality of American medicine requires the development and encouragement of plans for meeting the cost of unusual or prolonged illness; and

WHEREAS, a survey of methods already available for prepayment of costs indicates that facilities are in existence to provide for at least the most pressing demands;

Therefore, Be It Resolved, that the Management Committee is authorized, and the Administrator is authorized and instructed, to proceed with efforts designed to:

(a) Encourage the medical profession to active participation in the development of plans and the more general use of existing facilities to provide for easy payment of insurance against unusual or prolonged illness;

(b) Educate the people to the importance, nature and value of prepayment facilities, within the framework of principles approved by the medical profession, now available for meeting the costs of unusual illness;

(c) Investigate conditions relating to and inform industry concerning the principles underlying sound participation with employees in prepayment plans for meeting the cost of unusual or prolonged illness and hospitalization;

(d) Inform private insurance underwriters of the opportunity that is being offered through cooperation in nationwide efforts to provide group insurance policies for those needing or desiring insurance against the hazards of unusual illness;

(e) Encourage contributors and friends to a greater degree of participation in the efforts of the

National Physicians' Committee in this constructive program.

As one views this picture, there are two clearly defined and, in some respects, opposing points of view. One is that we are actually faced with a very real menace. This menace is at a point of crisis. It would appear that sound judgment would indicate that all efforts and all energies be devoted to strengthening and increasing the effectiveness of the machinery that is already available, to the end that the common enemy can be met with the strength of a united front. At the present time the mechanisms available are the A.M.A., the Council on Medical Care and Public Relations, and the National Physicians' Committee.

The other point of view is that the machinery available is not as efficient as new machinery might be; that, notwithstanding the emergency nature of the situation, we should devote time and energy to the development of completely new machinery. Anyone who knows anything about this understands that it would take months or even years to develop the effectiveness of this machinery. No one has any idea how effective it might become after the months or years of effort.

The National Physicians' Committee has definite elements of effectiveness. It could be immeasurably strengthened by unanimous support of medical groups. Under the circumstances, it seems to me that we should take advantage of every opportunity to unify physicians and medical groups. There is too little time to devote time and energy to the mere building of new types of instrumentalities which cannot be tested in battle until the mechanisms are perfected.

While waiting for the new Council to act and while waiting for these several projects to work out their own destiny and their worthy sphere of action and, more pertinently, while waiting for these projects to finance themselves for their survival, it might be well for us to agree that the N.P.C. is doing a fine and unusual job in public relations which is covering the whole forty-eight states. It is controlled by those who practice medicine but who are not indulging in the parade of science. These trustees of the National Physicians' Committee have been wise enough to erect a national program under expert guidance and at great expense. The committee has been able to finance its national program and has brought to the inadequate contributions of physicians enough outside support to pay the bills of a public relations program that is envied and applauded by competitive public relations experts. It has worked harmoniously with your parent American Medical Association. The National Physicians' Committee must live and act while you are devising any other program.

THE DECLINE OF APPENDICITIS

One of the outstanding public health achievements in the last 15 years has been the reduction of appendicitis from an important cause of death to one of minor rank. For few diseases have control measures produced so large a reduction in mortality during this interval.

The death rate from appendicitis has dropped among Metropolitan Industrial policyholders (ages 1 to 74) from 14.4 per 100,000 in 1929 to 5.2 in 1943, a decline of nearly two-thirds. The major part of this remarkable reduction has been achieved in the last four years, in which period the rate was cut almost in half.

Among children and adults of both sexes there have been appreciable gains against the disease. The greatest improvement has occurred between ages 5 and 44 years. The reductions in this age span range from 57 to 77 per cent. The gains among young children and elderly persons were less marked, probably because at these ages intestinal disturbances are so much more frequent that a case of appendicitis is more likely to go unrecognized until fatal complications have developed. * * *

Apparently these gratifying results have not been due to a lowered incidence of appendicitis. Although we have no conclusive data on the subject, reports of various investigators seem to indicate that the disease is not only more common today than it was a decade ago, but that its prevalence is still increasing.—*Statistical Bulletin, Metropolitan Life Insurance Company.*

WHY NOT A FASTING BLOOD SUGAR?

By HEYES PETERSON, M. D.
Wheeling, West Virginia

THE fasting blood sugar has been so long and so closely associated with the treatment of diabetes mellitus that many of us forget that it has definite limitations, and is by no means the most useful blood determination in the diagnosis or treatment of this disease. Although a fasting blood sugar has definite indications, the routine diagnosis and routine treatment of diabetes mellitus are much more easily and accurately accomplished by blood sugar determinations taken several hours after an average meal. The general practitioner treating diabetes will find that best results may be obtained by avoiding the routine use of the fasting test in his usual diabetic practice.

Joslin states that a fasting blood sugar which is over 130 milligrams per cent, or a blood sugar taken after the ingestion of food or sugar which is at any time over 170 milligrams per cent, is an indication of diabetes until proven otherwise. While it is true that a person with severe diabetes will usually have a fasting blood sugar definitely above 130, the person with moderate or mild diabetes (who still requires treatment) may have a fasting blood sugar at or slightly below this level, and a fasting blood sugar at or below 130 milligrams per cent does not definitely rule out the presence of diabetes in any given individual. A blood sugar test made one hour after the ingestion of 100 grams of glucose or about two hours after a substantial meal is a much better practical criterion of diabetes. The blood sugar at such times will usually be well over 170 even in the milder cases. There is a much greater variation between diabetic and nondiabetic readings after food than there is in the fasting condition, and a more accurate differentiation readily can be made.

It is the habit of many physicians, on discovering glycosuria, to send the patient immediately to a laboratory for a fasting blood sugar test. This practice may lead to somewhat uncertain results and is not to be recommended as a routine procedure. The patient, rather, should be instructed to eat a fairly heavy breakfast and to report for a blood sugar test about two hours after the completion of this meal, since a blood sugar test made at this time is actually a practical glucose tolerance test. When taken in this manner the blood sugar level is usually greatly above or below the arbitrary level of 170, and this single blood sugar determination will usually serve to establish the presence or absence of diabetes.

THE AUTHOR

Dr. Peterson, graduate Rush Medical College, University of Chicago; intern and resident at Kings County Hospital, New York City; Medical staff, Ohio Valley General Hospital, Wheeling.

The routine use of the fasting blood sugar test alone is inadvisable in the treatment of diabetes. Patients are usually given a morning dose of slowly absorbed protamine zinc insulin to provide a steady level of insulin throughout the twenty-four hours together with a morning dose of rapidly absorbed crystalline or regular insulin to provide increased action during the daylight periods of food ingestion. A fasting blood sugar test here will give no information as to how well the dosage of quick-acting insulin is controlling the patient's diabetes during the daylight hours. A much better idea is obtained by having blood sugar determinations made at two and one-half hour periods after meals, usually alternating them at successive visits between morning and afternoon hours. Blood sugar levels observed at these hours give an excellent idea of the degree of diabetic control obtained during the period of food intake and are much better criteria of diabetic con-

trol than are fasting blood sugars. As an example, it is easily possible for a person with diabetes to have a fairly normal fasting blood sugar in the morning before breakfast because of the prolonged effect of protamine zinc insulin and still have an abnormally high blood sugar and poor diabetic control through the daylight hours when the amount of insulin he receives is inadequate to control his dietary intake.

Fasting blood sugar tests are, of course, a vital part of the standard glucose tolerance test and of the convenient modification of Exton and Rose; they are also quite valuable in determining the amount of protamine zinc insulin to give, particularly during the period of control. If too much of this type of insulin is given, the fasting blood sugar will tend to be abnormally low, whereas, if not enough is given, it will be too high.

Since a fasting blood sugar does not offer as clear-cut a diagnostic differentiation and since the fasting blood sugar is less convenient and less indicative of good routine diabetic control, we recommend that less emphasis be placed upon it as the routine diagnostic and therapeutic procedure in the treatment of diabetes and that fasting blood sugars be obtained only where specifically required. The general practitioner, when treating diabetes, will find a blood sugar test made after meals to be much better adapted to his routine requirements.

FOOD PRESERVATION IN ANCIENT TIMES

Drying and smoking were popular means of food preservation in ancient times; salting in brine was also practiced, but not in America. No doubt some putrefaction occurred in the process of drying meat. One might think that such a condition would act as a deterrent to its widespread use. Yet in reality the reverse often seems to have taken place. Primitive man made the best of the situation and developed a liking for such "high" meat even to the extent of preferring it to plain meat. Some people's taste in cheese runs along similar lines.—*Nutrition Reviews.*

Tuberculosis Abstracts

Furnished Through the Courtesy of
The West Virginia Tuberculosis Association

The emphasis on early diagnosis of pulmonary tuberculosis would seem to be wasted if effective treatment is unnecessarily postponed. Discriminating selection of cases for collapse therapy, skillful choosing of the appropriate method and prompt employment of the elected procedure are indicated in the interest of all concerned.

Intrapleural Pneumonolysis

It seems generally agreed that at least half the cases of pulmonary tuberculosis require some form of collapse treatment, either reversible or irreversible. Thoracoplasty is the best surgical example of the latter, while the oldest technique devised—pneumothorax—is a good representative of temporary, reversible collapse of the lung.

The chest specialist is the one to select either method after he has evaluated the patient's condition and the stage of his tuberculosis. The mistaken belief that "time heals everything" must give way to acknowledgment that this disease demands immediate consideration invariably and active methods of treatment whenever indicated. In this race against time, presence of a cavity calls for measures to obliterate it before delay invites a hemorrhage or spread results in a hopeless condition.

Pneumothorax remains the first choice, but is successful in only about half the cases in which it is initially tried. Lack of success may be attributed to adherence of the two pleural surfaces so that collapse of the cavity is impossible or incomplete. Delay in the institution of pneumothorax may allow the parenchymal inflammation to progress and involve the pleurae until adhesions form and so defeat later attempts at what should have been a a simple collapse procedure.

Formerly, a risky method attempted to stretch or break such adhesions by forcing air into the pleural cavity under positive pressures. Serious complications developed if the adhesion, breaking off near the lung, tore the latter so that a tuberculous or mixed infection empyema resulted. Serious hemorrhage might follow rupture of a sizeable vessel incorporated in the adhesion. Precious time was often wasted while the hoped-for stretching of the

(Continued on page xxxi)

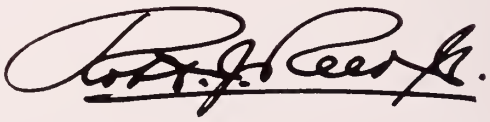
The President's Page

Are you all set and ready to go? If not, turn the pages and look over the program for our Annual State Meeting and I'm sure you will not be able to remain at home. A great program has been arranged, one of the best that has ever been presented to our Association.

I wish to express my deep appreciation to the Scientific Committee, especially its chairman, Dr. R. D. Gill, for his untiring efforts in the preparation of such a program. A large registration is expected. All available hotel rooms appear to have been reserved, but don't let this deter you. If you are unable to obtain reservations, get in touch with one of the members of the Committee on Arrangements, or with me, and we will see to it that you won't have to sit on a curbstone all night. So come one, come all, and bring your wives. A very interesting and delightful program has been arranged for the women, and then there is that Victory Dinner at the Wheeling Country Club on Tuesday evening.

As you know, this has been a quiet year in our state. We have all been so busy that we have had little time to stir up trouble. As far as I know, no fight is in the offing. Perhaps this is too bad. There is nothing like a good scrap to swell the attendance. So you'll just have to be satisfied with a bang-up program, plus a little fun on the side, and who among you isn't ready for a little relaxation.

To those of you who can't be here, to you who serve on foreign soil, or in distant parts, be assured that we will miss you more than can be told. You know, I am sure, that we will be thinking of you, and looking forward to that day when we will have our Victory Convention, and you, God willing, will be with us. Until then, the best of luck, and if on the evening of May 15th or 16th you experience a sense of loneliness, it will be because at that time some old croney will have just offered a toast to you.



President.

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THE WHEELING MEETING

With approximately one out of four West Virginia doctors in the military service, it is fitting that the Scientific Work Committee recognize both the Army and Navy in arranging the program for the annual meeting at Wheeling, May 15-16. At least four doctors high in the ranks of those serving in our armed forces, including two from our own state of West Virginia, are scheduled for addresses along with other outstanding members of the profession.

While the matter of hotel accommodations has developed into quite a problem, we are assured by the local committee on arrangements that comfortable rooms will be provided for all who wish to attend the meeting.

The scientific program this year is especially good, and the speakers who are taking time off to help make our annual meeting a success deserve a full attendance when they present their papers.

The warm and genuine hospitality of the people of Wheeling is known to most of the members of the Association. To those who have never attended a medical meeting there, it is sufficient to say that the members of the Ohio County Medical Society are prepared to offer the very best entertainment possible during these times of war.

Beginning at noon Sunday, May 14, and continuing through Tuesday evening, everything that goes to make a convention a real success has been provided by the program committee and the local Society. The scientific program itself offers much in the way of a refresher or postgraduate course for the general practitioner and those engaged in limited practice.

It will be possible for the doctor who attends the meeting to obtain a few hours' much needed and well deserved rest. The change, combining relaxation and recreation with the opportunity to hear addresses by some of the most prominent and successful doctors in the country, will better fit the doctor for continued hard work on the home front.

PAROXYSMAL HYPERTENSION

The investigations of Goldblatt, Page and others have served to raise the question of the possibility of surgical cure of hypertension. Experience has demonstrated that cure by nephrectomy is rarely to be expected and that operation on the autonomic nervous system at best offers relief for an uncertain period. With the increasing frequency of hypertensive vascular disease there is no doubt that the future will show more and more clarification of the whole problem.

From the numerous varieties of hypertension, it now seems possible that those cases of paroxysmal hypertension due to tumors of the adrenal (pheochromocytoma) offer excellent prospect of cure. These hormone producing tumors are mostly benign in contrast to the ganglionic (nervous) cell tumors which are likely to be extremely malignant.

Symptomatically the findings are those resulting from an over dose of adrenalin. In predisposed individuals attacks may be produced by those emotions calling for increased adrenalin output as well as by change of position, increase of activity, massage of the abdomen, etc. Blanching of peripheral por-

tions of the body is common during the attack. While blood pressure may be normal or slightly above between attacks, during attacks it may rise to 300 mm. or over. The attacks may come infrequently or as often as every one-half hour. They may last from a few minutes to as long as thirty-six hours. Prolonged attacks are especially dangerous and may be followed by shock and death.

Beer[1] demonstrated the presence of pressor substance in the blood during the attack and concluded that it was undoubtedly adrenalin. Hyman and Mencher[2] state that positive diagnosis depends upon four findings: (1) Typical attack, (2) evidence of pressor response to adrenalin, histamine, emotions or mechanical stimulation of suprarenal region, (3) perfusion studies that demonstrate pressor substance in the blood at the height of the attack and, (4) x-ray demonstration of the adrenal tumor after perirenal insufflation.

Biskind et al[3] reviewed the literature in 1941 and reported twenty-nine cases. Hyman and Mencher add three cases of their own and three from other sources, making a total of thirty-five cases having undergone operation. The combined series shows five postoperative deaths and one, the only malignant case reported, two years postoperative from metastases. All reports emphasize that if operation is done before arteriosclerosis results, the blood pressure returns to normal and the attacks do not recur.

All reports also emphasize that the condition is rare. Quite possibly this can be interpreted to mean that the condition hitherto has been rarely recognized. It may be significant that four of the thirty-five diagnosed cases are reported from one institution. The evidence available indicates that diagnosis is possible with the means at hand in any well equipped hospital, and that good results follow from operation. Paroxysmal hypertension due to pheochromocytoma of the adrenal represents one small but orderly corner in the chaotic field of hypertension disease.

1. Beer, E., King, F., and Prinzmetal, M.: Pheochromocytoma with demonstration of a pressor substance in the blood: Ann. Surg. 106: 85, 1937.

2. Hyman, A., and Mencher, W.: Pheochromocytoma of adrenal gland: Jour. Urol., 49: 755, 1943.

3. Biskind, G. R., Meyer, M. A., and Beadner, S.: Pheochromocytoma cured by surgical intervention. J. Clin. Endocrinol., 2: 113, 1941.

MEDICAL PHARMACOLOGY

Dr. Harvey B. Haag, head of the Department of Pharmacology at the Medical College of Virginia, believes that cooperation between colleges of pharmacy and medicine offers many possibilities for improving professional relations and making the work of both professions more effective. In a recent issue of "The Virginia Pharmacist," he says that one of the most difficult problems in the teaching of medical students is that of prescription writing.

"Perhaps no single facet of medical instruction is so frequently the butt of adverse criticism," he says, "not only from physicians themselves but from those responsible for compounding prescriptions, namely pharmacists. Those who teach pharmacology to medical students are well awere of this situation, and many have been the methods used in attempting a solution."

Dr. Haag points out that a prescription is really a message from a physician to a pharmacist. "The better these two understand one another," he says, "the more smoothly will this message be interpreted and executed."

Several years ago the School of Pharmacy at the Medical College of Virginia was asked to aid in the teaching of prescription writing to medical students. This cooperation was given. At present, according to Doctor Haag, during the regular pharmacology course, eight lectures are given by Dr. T. D. Rowe and Dr. Karl Kaufman in which the more common pitfalls and errors of prescription writing, as the pharmacist sees them, are brought to the attention of the medical students. Other problems of mutual concern, such as, for instance, the intricacies of the narcotic laws, are also discussed.

"While this program has now been in progress too short a time for final evaluation," says Doctor Haag, "it is already evident that this addition to the teaching of medical pharmacology is bearing fruit, and it is planned to continue this cooperative scheme on a more elaborate scale in the coming years. Fundamentally this would seem to be a sensible and logical procedure and for us here at the college, because of our unique organization, an especially feasible plan."

DIASONE AGAIN

The publicity which has been given by the lay press to diasone and related chemicals as tuberculosis "cures" has been of such a volume and tone as to stimulate the *spes phthisica* in the victims of the bacillus of Koch to a fever heat. It is accordingly essential that the medical profession know as promptly as possible the actual curative value of all such drugs. Hence the Committee on Therapy of the American Trudeau Society presents in the April issue of *The American Review of Tuberculosis* its conclusions as to the actual therapeutic worth of these drugs in so far as the present state of our knowledge justifies conclusions. In order that the West Virginia profession may have this information, we quote the entire report:

"The Committee on Therapy of the American Trudeau Society (Medical Section of the National Tuberculosis Association) in session March 17 and 18, 1944, at Chicago and Waukegan, Illinois, has reviewed information so far made available to it on the effects of promin, diasone, promizole, diaminodiphenylsulfone and some related drugs upon previously established experimental tuberculosis in guinea pigs. It has also reviewed the very limited amount of roentgenological and clinical data from one institution so far made available regarding patients treated with one of the drugs; viz. diasone. On the basis of these data the following statement has been authorized:

"Promin, diasone, promizole, and certain related compounds appear to possess in varying degree the striking ability to restrain the development of experimental tuberculosis in guinea pigs. It is recognized that experimentally induced tuberculosis in guinea pigs offers many contrasts with clinical tuberculosis in human beings, even though the causative organism is the same.

"It is the opinion of the Committee that the clinical and roentgenological data so far made available to the Committee on the action of diasone in human tuberculosis is as yet inadequate both quantitatively and qualitatively to permit, even tentatively, a positive evaluation of its curative effects upon tuberculosis in humans. The Committee believes that there is at this time no adequate basis for the optimistic implications of the magazine articles or of the releases to the press which are now so well known to both the profession and public. It is believed, on the contrary, that such implications are distinctly unwarranted and not in accord with the clinical evidence which has been reviewed by the Committee. The Committee regrets exceedingly that the magazine articles mentioned previously were published in spite of efforts on the part of both the Committee and the clinician quoted to stop their publication.

"Until controlled studies of adequate scope have been reported it is recommended that none of these drugs be used for treating tuberculous patients except under conditions which will appreciably add to our knowledge of their clinical action, and in the presence of adequate facilities to protect patients effectively from their potentially serious toxic effects. Patients and physicians must also be reminded of the provisions of the federal regulations which prohibit the distribution of a drug in the experimental phase of development to other than research institutions to which the material is assigned by the manufacturer for either laboratory or clinical investigation. The Committee is informed that other clinical investigations are now in progress, and it is the expressed opinion of the Committee that such further well-controlled clinical investigation is distinctly desirable.

"Any use of chemotherapeutic agents, including diasone, in the treatment of tuberculous patients must, therefore, be regarded as purely a project in clinical investigation. It must be again emphasized that such use is not without hazard and that the roentgenological and clinical evidence reviewed by the Committee gives no justification at this time for any attitude concerning the value of these drugs in patients other than one of critical interest."

General News

PROGRAM COMPLETED FOR ANNUAL MEETING AT WHEELING, MAY 15-16

For the third successive year, sectional meetings in connection with the program for the annual meeting of the State Medical Society, which will be held at Wheeling, May 15-16, have been dispensed with in favor of general sessions open to all of the members. The varied character of the program, coupled with the prominence of speakers who have accepted invitations, assure continuous interesting scientific sessions throughout the convention, which is again being streamlined to two days.

Full Program

The convention will be formally opened at 9:30 o'clock Monday morning, May 15. Sessions of the House of Delegates will be held Monday and Tuesday afternoons at 4:30 o'clock. The oration on surgery will be given the first day, and the oration on medicine the afternoon of the second day. The president's annual address is scheduled for Monday night, and the "Victory Dinner" for Tuesday evening at the Wheeling Country Club.

The program, which is printed in full in this issue of The Journal, includes the names of speakers who need but little, if any, introduction to West Virginia doctors. While only a few of them have been present at medical meetings in this state, all are prominent in their own fields of medicine and surgery.

No Discussion

The program committee, which is composed of Dr. R. D. Gill, of Wheeling, chairman, and Drs. T. L. Harris, of Parkersburg, and J. P. McMullen, of Wellsburg, have adopted the question and answer period following each address which proved to be so successful at the last two annual meetings. There will be no discussion, but a question period has been arranged following the presentation of each scientific paper, with the guest speaker in charge.

Start on Time

All meetings will start and end promptly on time. There can be no overlapping of sessions, as a full three days' program is being presented in two days. The section and society luncheons will be served at the Windsor and McLure hotels promptly at 12:15 each day in order that those who attend may return to the ballroom in time for the beginning of the afternoon sessions.

Registration

The registration desk will be opened on the mezzanine at the Windsor at two o'clock Sunday afternoon, May 14. Doctors are urged to register promptly upon their arrival in Wheeling. There is no registration fee.

Practically all available hotel rooms have been reserved, but the Housing Committee will find comfortable quarters for those who do not already have reservations. This committee is composed of Drs. M. B. Williams, Howard T. Phillips and Russell B. Bailey.

Committee on General Arrangements

The local committee on arrangements named by Dr. Robt. J. Reed, Jr., president of the State Medical Association, is composed of Dr. M. B. Williams, chairman, and Drs. W. C. McCuskey, Russell Bond, Howard T. Phillips, Russell B. Bailey, D. E. Greeneltch, Charles H. Clovis, Edward Pell, and Ivan Fawcett.

OFFICIAL CALL FOR CONVENTION

Charleston, West Va.
April 20, 1944

To the Officers and Members of the West Virginia State Medical Association:

The 77th annual meeting of the West Virginia State Medical Association will be held at Wheeling, West Virginia, May 15-16, 1944. Headquarters will be established at the Windsor Hotel.

The House of Delegates will convene for the first session Monday afternoon, May 15. The second session will be held Tuesday afternoon, May 16.

The Scientific Assembly of the Association will open with the general meeting Monday, May 15, at 9:30 A. M. The annual address of the President will be delivered that evening.

R. J. REED, JR., M. D.,
President.

Attest:
CHARLES LIVELY,
Executive Secretary.

PUBLIC HEALTH COUNCIL MEETS

Several applicants for licensure in West Virginia will be examined by the Public Health Council at the regular spring meeting which will be held at the Daniel Boone Hotel, Charleston, May 1-3.

SPEAKER URGES RESUMPTION OF PUBLIC HEALTH INSTITUTES IN STATE

Dr. Orlen J. Johnson, member of the Council on Industrial Health of the American Health Association, led a roundtable discussion on problems concerning health and hygiene in industry at a meeting of the Committee on Industrial Health of the West Virginia State Medical Association, at the Daniel Boone Hotel, Charleston, April 10, 1944.

The meeting, which was in charge of Dr. E. F. Gott, of Charleston, Chairman of the committee, was also attended by Drs. E. N. Pell, of Wheeling, and W. F. Rogers, of Parkersburg, members, and Drs. J. J. Brandabur, Huntington; C. Scott McKinley, W. C. Stewart, J. E. Offner, W. A. McMillan, E. B. Henson, J. Bankhead Banks, and R. L. Anderson, all of Charleston; R. H. Dunn, of South Charleston; and Mr. Charles Lively, secretary *ex officio*.

Dr. Johnson pointed out that doctors are beginning to realize the relationship between medicine and industrial health, and that every industrial plant should have a medical director who spends a large part of his time in the plant, and who should investigate sanitary facilities, have the air checked, and perform other duties looking to the health and safety of the employees. Discussing the rehabilitation of men now in the armed forces, he said that "while the government will repair these men as much as possible physically, it is up to industrial plants to make a place for them when they are returned from active service with the military forces."

Dr. Johnson expressed the hope that industrial health institutes would again be held in West Virginia during 1944. These institutes were suspended after 1942. He suggested that each component medical society devote at least one meeting each year to industrial health, inasmuch as about 90 per cent of the doctors in private practice, in our cities and industrial areas, engage to some extent in industrial practice. He said that each component society should be encouraged to provide a committee on industrial health, as the job is too big for the one state committee to handle.

ANNUAL MEETING OF AUXILIARY

The 20th annual meeting of the Woman's Auxiliary to the West Virginia State Medical Association will be held at Wheeling, May 15-16, simultaneously with the 77th annual meeting of the State Medical Association. All sessions will be held at the McLure Hotel.

Business to be transacted the first day will be limited to committee and board meetings. The annual luncheon is scheduled for one o'clock on Monday at the Wheeling Country Club, with Mrs. Arley V. McCoy presiding as hostess. Captain W. M. Sheppe (MC), USNR, formerly of Wheeling, but now assigned to the U. S. Naval Hospital at Quantico, Virginia, will deliver the principal address. His subject is, "Recent Advances in Medical Care of Naval Personnel." Honor guests will include Mrs. Eben J. Carey, national president of the Auxiliary, Dr. Robt. J. Reed, Jr., president of the State Medical Association, and the members of the advisory board.

The convention will be formally opened Tuesday morning, May 16, with Mrs. John P. Helmick, president, presiding. The morning session will be followed by a luncheon at Washington Farms, with Mrs. E. M. Phillips as hostess. The post-convention meeting of the board will be held at 3:30 o'clock.

Mrs. Scott A Ford, of Beckley, is the president elect of the Auxiliary, and she and the other elective officers will be installed Tuesday morning by Mrs. Carey, national president.

SCIENTIFIC EXHIBITS AT WHEELING

Scientific exhibits will be set up in the Riverview Room, just off the lobby at the Windsor Hotel, at the annual meeting in that city, May 15-16. Exceptionally interesting exhibits have been arranged by the committee in cooperation with West Virginia doctors and hospitals, the state health department, and the American Medical Association. The committee is composed of Drs. Hu Myers, of Philippi, chairman, John P. Helmick, of Fairmont, and Fred R. Whittlesey, of Morgantown.

COMMITTEE MEETINGS AT CONVENTION

The annual meeting of the publication committee will be held Sunday afternoon, May 14, at one o'clock, and will be followed by a special meeting of the fact finding and planning committee at three o'clock. The pre-convention meeting of the council is scheduled for Sunday evening at six o'clock. All meetings will be held in the Colonial Room at the Windsor Hotel.

DR. OFFNER APPEALS TO DOCTORS FOR AID IN SOLVING TB PROBLEMS

Cooperation on the part of all practicing physicians in the efforts of the State Health Department to put a stop to the exodus of patients from the state TB sanatoria to accept jobs in defense plants is urged in an appeal from Dr. J. E. Offner, State Health Commissioner, directed particularly to "family doctors" in West Virginia.

Citing the fact that the attention of the State Health Department has been called to the number of patients afflicted with tuberculosis in a communicable stage who are leaving state sanatoria, Dr. Offner stated that every control measure within the power of the department has been tried in an effort to prevent this exodus, which is presenting an appalling health hazard.

Doctor Offner stated that the "family doctor" is in the best position to convince the patient that proper care and hospitalization now will enable him to return eventually to society, where he may resume normal activities. These physicians, he believes, can bring home to the patient the dangers of active tuberculosis, not only to himself, but to his family, neighbors, and the community in which he lives, and the importance of complete isolation as the most effective control measure.

STATE HEALTH CONFERENCE

The annual State Health Conference, embracing joint sessions of the State Health Officers Conference and the West Virginia Public Health Association, which will meet at the Daniel Boone Hotel, Charleston, May 1-3, will feature addresses by several outstanding authorities in public health service. Subjects will include industrial hygiene, communicable disease control, public health nursing, infant care and compulsory hospitalization.

A tropical and war-time diseases forum is scheduled for May 2, the speakers being Major R. H. Kunstadter, MC, Ashford General Hospital, Lt. Comdr. E. M. Bingham (MC), USNR, National Naval Medical Center, Bethesda, Maryland, and Miss K. E. Cox, director of the State Hygienic Laboratory, Charleston.

The annual dinner will be held Tuesday evening, May 2, at the Daniel Boone Hotel. Dr. W. K. Sharp, Jr., Director of District No. 2 of the USPHS, Bethesda, Md., will serve as toastmaster, and the principal address will be delivered by Max Fullerton, chief of the Associated Press Bureau at Charleston, his subject being, "Publicity Mediums During War Times." Section group meetings will be held on the afternoon of May 2, and a tour of the new Kanawha Valley Medical Center is scheduled for the morning of May 3, to be followed by a luncheon at the Medical Center.

Dr. N. G. Angstadt, director of the bureau of county health work in the state health department, is president of the West Virginia Public Health Association, and Miss Annette King, acting director of the bureau of public health education and public relations, is the secretary.

RELOCATIONS

Dr. Frank J. Burian, of McVeigh, Kentucky, has located at Williamson.

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Dr. John P. Heagarty, who was formerly located at Ward, is now practicing at Stirrat, in Logan County.

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Dr. Ernest McClellan, who has been located at Williamson for several years, has moved to Stollings, Logan County.

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Dr. C. H. Goodykoontz, Jr., has moved from Bluefield, to Bishop, Virginia.

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Dr. F. G. Harper, of West Union, has relocated for the practice of medicine at Cincinnati.

HARRISON COUNTY APPROVES PLAN

The Harrison County Medical Society has approved the medical-surgical plan now being administered by Medical-Surgical Service, Inc., at Clarksburg. The plan, which conforms with the basic contract provided by the Fact Finding and Planning Committee of the West Virginia State Medical Association for the use of component societies, and which will be operated as a twin organization with the Monongahela Valley Hospital Service, will be under the management of Harold Rodeheaver, who for several years has served as treasurer and manager of that organization.

The plan as approved provides full coverage for those in the low income group. Medical and surgical care in a hospital will be provided for a total of 42 days during a year. Obstetrical cases will be cared for both in homes and in hospitals.

CONVENTION PROGRAM
77th ANNUAL MEETING
OF THE
West Virginia State Medical Association
WINDSOR HOTEL, WHEELING
May 15-16, 1944

SUNDAY AFTERNOON
May 14

1:00—Meeting of the Publication Committee.
Dr. Walter E. Vest, *presiding*.

2:00—Registration, Mezzanine, Windsor Hotel.

3:00—Meeting of Fact Finding and Planning Committee.
Dr. Ray M. Bobbitt, *presiding*.

6:00—Meeting of the Council.
Dr. R. J. Wilkinson, *presiding*.

MONDAY MORNING
May 15

9:30—Call to Order—Dr. Robert J. Reed, Jr., President, Wheeling.

Invocation—Rev. Martin L. Gerhart, Pastor, First Presbyterian Church, Wheeling.

Address of Welcome—Dr. Arley V. McCoy, President, Ohio County Medical Society, Wheeling.

Response—Dr. Frank V. Langfitt, Clarksburg.

10:00—"The Medical and Surgical Complications of Pregnancy."

Dr. S. A. Cosgrove, Medical Director and Superintendent of the Margaret Hague Maternity Hospital, Jersey City, N. J.

The large material of one clinic will be reviewed with reference to the medical and surgical complications of pregnancy which have been presented in that material, with certain illustrative case outlines, to develop the almost axiomatic proposition that such complications should, in general, be treated and managed exactly as though the pregnancy did not exist as a concomitant condition.

Dr. W. E. Hoffman, *presiding*.

11:00—"What is the Matter with the Patient Who is Always Tired?"

Dr. Walter C. Alvarez, Mayo Clinic, Rochester, Minn.

Innumerable patients complain of a distressing fatigue for which usually no adequate cause can be found even with the most careful examination. Sometimes the patient is in a nervous breakdown. The physician must find out if the patient has had enough strain to produce such a break. If not, he will often find that there is bad nervous heredity. Characteristic of the nervous type of fatigue is the fact that it is worse in the morning after the night's rest. It is not due to the day's work.

Dr. James L. Wade, *presiding*.

MONDAY AFTERNOON

12:15—Society and Section Luncheons (As Announced).

2:00—ORATION ON SURGERY.

"Surgical Experiences in a Continental U. S. Naval Hospital."

Lt. Comdr. John O. Rankin (MC), USNR, U. S. Naval Hospital, Memphis, Tennessee.

Derived from experiences obtained on an orthopedic service composed of from 150 to 200 patients, who have received injuries either on distant battlefields or at the local aviation training center. The pathology is of both the acute and chronic type. An endeavor is made to discuss some of the more common fractures and other allied traumas, methods of treatment and pitfalls to be avoided, with a demonstration by lantern slide of the end results obtained.

(Lantern slides.)

Dr. R. J. Reed, Jr., *presiding*.

2:45—"The Diagnosis and Management of Malaria."

Major Ralph H. Kunstadter, MC, Ashford General Hospital, White Sulphur Springs, West Virginia.

The many diagnostic problems which arise in troops returning from overseas in areas where malaria is endemic are emphasized. The atypical nature of relapses, as well as primary attacks, frequently taxes to the utmost the clinical judgment of not only the internist, but also the surgeon. The various clinical features, acute and chronic, will be discussed, and the various practical laboratory procedures will be considered. The most recent accepted treatment, with emphasis on the severe cases and the management of complications, will be dealt with.

(Lantern slides.)

Dr. Richard D. Gill, *presiding*.

3:30—"The Differential Diagnosis and Treatment of Diseases Involving the Spleen."

Dr. Charles A. Doan, Professor and Chairman, Department of Medicine, Ohio State University College of Medicine, Columbus, Ohio.

The spleen is no longer the "organ of mystery" whose normal functions and pathologic dysfunctions defied recognition and correction until very recently. The currently accepted physiologic activities of this important organ will be briefly reviewed as a basis for the discussion of a variety of clinical syndromes, some of them newly recognized, whose underlying pathology resides in the spleen. The spleen may be an asset to the body defenses under certain circumstances, or a liability under others. The means of differentiating between these conditions as a basis for establishing the indications vs. contraindications for splenectomy will be illustrated.

Dr. Frank J. Holroyd, *presiding*.

4:30—HOUSE OF DELEGATES (First Session) Ballroom.

MONDAY EVENING

7:00—Past President's Dinner—Dr. Robert J. Reed, *Host*.

9:00—ADDRESS OF THE PRESIDENT.

"Beyond the Blue Horizon."

Dr. R. J. Reed, Jr., Wheeling, W. Va.

Dr. H. G. Steele, *presiding*.

TUESDAY MORNING

May 16

9:00—"Recent Advances in the Treatment of Purulent Meningitis."

Dr. W. W. Waddell, Jr., Associate Professor of Pediatrics, University of Virginia Medical School, Charlottesville, Virginia.

Experiences with the various types of purulent meningitis with particular reference to influenzal meningitis, and the old and new methods of treatment, will be described.

(Lantern slides.)

Dr. Andrew E. Amick, *presiding*.

10:00—"Surgery of the Upper Gastro-Intestinal Tract."

Dr. Richard B. Cattell, Lahey Clinic, Boston, Mass.

Surgical treatment of carcinoma of the lower end of the esophagus and the stomach will be outlined, including subtotal and total gastrectomy. Indications for operation for ulcer of the stomach, duodenum, and jejunum will be listed and the results of operation presented. Experiences with resection of the head of the pancreas for carcinoma of the duodenum and ampulla of Vater will be discussed.

(Lantern slides.)

Dr. J. B. Clinton, *presiding*.

11:00—"The Rôle of Exophthalmos in the Differential Diagnosis and Treatment of Graves' Disease."

Dr. Francis H. Adler, Professor of Ophthalmology, University of Pennsylvania Medical School, Philadelphia, Pa.

The earliest signs of Graves' disease are those associated with the lids. These signs usually disappear after successful thyroidectomy. The exophthalmos which comes later and persists even after thyroidectomy is due to changes in water balance of the orbital tissue and depends upon some upset in the thyrotropic hormone of the pituitary. Cases are frequently seen and fairly generally recognized where thyroidectomy results in a marked progressive increase in the exophthalmos. They must be recognized as operation is contraindicated. Their differential diagnosis is discussed.

(Lantern slides.)

Dr. J. S. Maxwell, *presiding*.

TUESDAY AFTERNOON

12:15—Society and Section Luncheons (As Announced).

2:00—ORATION ON MEDICINE.

"Growing Children—Our Responsibility."

Dr. Andrew E. Amick, Charleston, West Virginia.

No one professional or social group has a monopoly of interest and responsibility for children's health. Better health supervision for the growing child will result not from the activities of one group or one organization, but from the harmonious working together of many groups.

(Lantern slides.)

Dr. R. J. Reed, Jr., *presiding*.

2:45—"Observations in Disease Control Methods Among Overseas Troops."

Lt. Colonel John W. R. Norton, MC, Office of the Surgeon General, Washington, D. C.

From the standpoint of preventive medicine, the principal problems overseas are the control of malaria, intestinal diseases, and venereal diseases. Observations following six months' experience in Britain, and a little over a year in North Africa and Sicily.

Dr. Thomas L. Harris, *presiding*.

3:30—"Medicine in the South Pacific."

Captain Alphonse McMahon, (MC), USNR, Bureau of Medicine and Surgery, U. S. Naval Hospital, Bethesda, Md.

The practice of medicine in outlying posts in the South Pacific varies with the locale and the type of existing military activity. It is concerned with the prevention of diseases peculiar to the tropics and with the maintenance of the general health of the military personnel. Landing and setting up operations create sanitary and medical problems that are important to the health of the troops.

Dr. Richard D. Gill, *presiding*.

4:30—House of Delegates (Second Session) Ballroom.

Election of Officers.

TUESDAY EVENING

6:30—Reception, Wheeling Country Club, Staff of Wheeling Clinic, *Hosts*.

8:00—Victory Dinner, Wheeling Country Club.

Capt. W. M. Sheppe, (MC), USNR, *Toastmaster*.

Guest speakers:

Lt. Col. John W. R. Norton, MC, AUS.

Capt. Alphonse McMahon, (MC), USNR.

CONVENTION SPEAKERS

DR. FRANCIS H. ADLER, Professor of Ophthalmology, University of Pennsylvania School of Medicine, Philadelphia; graduated from that school in 1919, and interned at the University Hospital; surgeon in Wills Eye Hospital, 1934-37, and consulting surgeon to date; Professor of Ophthalmology as above since 1937.

DR. WALTER C. ALVAREZ, Mayo Clinic, Rochester, Minnesota; Professor of Medicine at the University of Minnesota Graduate School of Medicine; graduated from Stanford Medical School; did research and taught at the University of California until 1926; author of Nervous Indigestion, (1930), An Introduction to Gastroenterology, (1940), Nervousness, Indigestion and Pain (1943), and articles on Diseases of the Digestive Tract published in Oxford Medicine; editor of Gastroenterology and past president of the American Gastroenterological Association.

DR. ANDREW E. AMICK, Charleston, West Virginia; graduated from Medical College of Virginia; interned Willard Parker Hospital, and served two years' residency at the Babies Hospital, New York City; Chairman, Section on Pediatrics, West Virginia State Medical Association.

DR. RICHARD B. CATTELL, Lahey Clinic, Boston, Mass.; graduated from Harvard Medical School; interned at St. Luke's Hospital, New York, for two years, and has been on the surgical staff at Lahey Clinic ever since; on the staff of the New England Deaconess and New England Baptist Hospitals.

DR. S. A. COSGROVE, medical director and superintendent of Margaret Hague Maternity Hospital, Jersey City, N. J.; graduated from Cornell Medical School; Clinical Professor of Obstetrics, Faculty of Medicine, Columbia University, with reference to postgraduate work at the hospital; American Board of Obstetrics and Gynecology.

DR. CHARLES A. DOAN, Professor and Chairman, Department of Medicine and Director of Medical Research, Ohio State University, Columbus, Ohio; graduate of Johns Hopkins; formerly at Thorndike Memorial Laboratory and Harvard Medical School, Boston, and Rockefeller Institute for Medical Research, New York City.

MAJOR RALPH H. KUNSTADTER, MC, Ashford General Hospital, White Sulphur Springs, W. Va.; Chief of the Communicable Disease Section; formerly Associate Attending Pediatrician, Michael Reese Hospital, Chicago; American Board of Pediatrics; graduate University of Illinois College of Medicine, Chicago.

CAPTAIN ALPHONSE MCMAHON, (MC) USNR, Bureau of Medicine and Surgery, U. S. Naval Hospital, Bethesda, Md.; formerly senior instructor in medicine, St. Louis University School of Medicine; Past President of the St. Louis Medi-

cal Society; Past Vice-President of the American Medical Association.

LT. COL. JOHN W. R. NORTON, MC, Acting Director, Epidemiology Division, Army Service Forces, Office of the Surgeon General, Washington, D. C.; formerly Professor of Public Health Administration, University of North Carolina School of Medicine; graduate Vanderbilt University School of Medicine; Public Health degree from Harvard University; recently medical inspector and member of preventive medicine division with the overseas forces.

LT. COMDR. JOHN OLIVER RANKIN, (MC), USNR, Chief of Orthopedic Surgery, U. S. Naval Hospital, Memphis, Tennessee; formerly member of the surgical staff of the Wheeling Clinic, Wheeling, W. Va.; chairman of the regional fracture committee of the American College of Surgeons.

DR. ROBERT J. REED, JR., Wheeling, W. Va.; graduated from University of Pennsylvania School of Medicine; interned and served residency at University Hospital; Fellow American College of Surgeons; President of West Virginia State Medical Association.

DR. WILLIAM W. WADDELL, JR., Associate Professor of Pediatrics and acting head of the Pediatric Department, University of Virginia Department of Medicine, Charlottesville, Va.; graduate of the same school; has been associated with the University of Virginia medical school for the past twenty-one years.

DELEGATES AND ALTERNATES

B-R-T (3)—Delegates, Drs. Guy H. Michael, Parsons; Hu C. Myers, Philippi; and W. G. Harper, Elkins.

BOONE COUNTY (2)—Delegates, Drs. J. Paul Aliff, Nellis; H. H. Howell, Madison. Alternates, Drs. A. C. Lewis, Seth; W. V. Wilkerson, Prenter.

BROOKE COUNTY (1)—Delegate, Dr. C. R. Megahan, Follansbee.

CABELL COUNTY (6)—Delegates, Drs. C. D. Genge, W. C. Swann, T. G. Folsom, C. B. Wright, W. F. Beckner, and R. M. Sloan, Huntington. Alternates, Drs. C. G. Willis, E. J. Humphrey, R. S. Van Metre, Jay Hutchison, and G. A. Ratcliff, Huntington.

CENTRAL W. VA. (2)—Delegates, Drs. J. M. Coger, Bergoo; and W. B. Forman, Buckhannon. Alternates, Drs. Eugene Brown, Summersville; and J. C. Eakle, Sutton.

DODDRIDGE COUNTY (1)—Delegate, Dr. A. Poole, West Union. Alternate, Dr. R. S. White, West Union.

EASTERN PANHANDLE (2)—Delegate, Dr. G. O. Martin, Martinsburg.

FAYETTE COUNTY (3)—Delegates, Drs. Eugene S. Carter, Jr., Boomer; W. E. Bundy, Minden; and J. Marshall Carter, Glen Ferris. Alternates, Drs. Claude Frazier, Winona; and J. B. Thompson, Oak Hill.

GREENBRIER VALLEY (2)—Delegates, Drs. Herbert Duncan, Lewisburg; and H. D. Gunning, Ronceverte. Alternate, Dr. A. G. Lanham, Ronceverte.

HANCOCK COUNTY (2) — Delegates, Drs. Thomas Slate, Weirton; and A. B. Rinehart, Weirton. Alternate. Dr. L. O. Schwartz, Weirton.

HARRISON COUNTY (4)—Delegates, Drs. J. C. Kerr, H. V. Thomas, C. O. Post, and J. E. Wilson, Clarksburg. Alternates, Drs. W. T. Gocke, D. H. Lough, and B. S. Brake, Clarksburg.

KANAWHA (10)—Delegates, Drs. W. Paul Elkin, Geo. F. Grisinger, Hugh A. Bailey, A. A. Wilson, W. W. Point, E. W. Squire, A. Spates Brady, Jr., W. C. Stewart, D. N. Barber, and V. L. Lance, Charleston. Alternates, Drs. E. O. Vaughan, P. R. Gerhardt, G. P. Heffner, W. E. Hoffman, D. A. Dent, F. A. Clark, J. E. Rucker, and Comdr. P. A. Haley II (MC), USNR, Charleston.

LEWIS COUNTY (2)—Delegates, Drs. Albert E. Long, and Theresa Snaith, Weston. Alternates, Drs. A. F. Lawson and E. R. Cooper, Weston.

LOGAN COUNTY (3)—Delegates, Drs. T. H. Millman, Earling; J. W. Carney, Logan; and Frank Jamison, Dehue.

MARION COUNTY (3)—Delegates, Drs. John P. Helmick, and G. V. Morgan.

MARSHALL COUNTY (2)—Delegates, Drs. J. A. Striebich and S. F. Yoho, Moundsville. Alternates, Drs. O. P. Wilson and R. A. Ashworth.

MASON COUNTY (1)—Delegate, Dr. M. Koenigsberg, Point Pleasant. Alternate, Dr. Frank Long, Point Pleasant.

McDOWELL COUNTY (4)—Delegates, Drs. Irvine Saunders, and W. R. Counts, Welch; R. V. Shanklin, Gary; and J. A. Bennett, Algoma. Alternates, Drs. C. T. Clark and J. K. Pickens, Iaeger; H. P. Evans, Keystone; and C. W. Vick, Jenkinjones.

MERCER COUNTY (3)—Delegates, Drs. Frank J. Holroyd, Princeton; J. R. Shanklin, and D. B. Lepper, Bluefield. Alternates, Drs. Frank Huff, Bluefield; and B. S. Clements, Matoaka.

MINGO COUNTY (2)—Delegates, Drs. John C. Lawson, and George W. Easley, Williamson. Alternate, Dr. H. C. Hays, Williamson.

MONONGALIA COUNTY (3)—Delegates, Drs. C. F. Dent, E. F. Heiskell, and Eldon B. Tucker, Morgantown. Alternate, Dr. G. R. Maxwell, Morgantown.

OHIO COUNTY (5)—Delegates, Drs. R. W. W. Phillips, J. G. Thoner, R. J. Armbrecht, Ivan Fawcett, and M. B. Williams, Wheeling. Alternates, Drs. S. W. Tretheway, R. J. Snider, J. C. Hazlett, and C. G. McCoy, Wheeling.

PARKERSBURG ACADEMY (4)—Delegates, Drs. W. F. Rogers, Dana T. Moore, and A. M. Dearman, Parkersburg; and Curtis P. Artz, Grantsville. Alternates, Drs. H. E. Gaynor, Orva Conley, and O. J. Casto, Parkersburg.

POTOMAC VALLEY (2)—Delegates, Drs. E. A. Courrier, and Thomas Bess, Keyser. Alternate, Dr. R. W. Love, Moorefield.

PRESTON COUNTY (2)—Delegates, Drs. C. Y. Moser, Kingwood; and H. D. Ireland, Hopemont. Alternates, Drs. C. E. Smith, Terra Alta, and H. C. Smith, Eglon.

RALEIGH COUNTY (4)—Delegates, Drs. S. S. DuPuy, Cranberry, W. C. Covey, Winding Gulf, S. A. Ford, and L. M. Halloran, Beckley. Alternates, Drs. A. G. Bowles, Glen White; R. P. Daniel, Pemberton; F. J. Moore, Affinity; and T. U. Vermillion, Beckley.

SUMMERS COUNTY (1)—Delegate, Dr. D. W. Ritter, Hinton; and Alternate, Dr. W. L. Van Sant, Hinton.

TAYLOR COUNTY (1)—Delegate, Dr. Paul P. Warden, Grafton.

WETZEL COUNTY (2)—Delegates, Drs. E. C. Blum, and J. O. Theiss, New Martinsville. Alternates, Drs. K. M. Hornbrook, New Martinsville, and A. M. Dyer, Pine Grove.

WYOMING COUNTY (2)—Delegate, Dr. J. F. Biggart, Mullens.

SPECIAL SECTION LUNCHEONS

Monday, May 15

12:15—(Windsor Hotel). West Virginia Heart Association and American College of Physicians. Dr. Walter C. Alvarez, Rochester, Minn., and Dr. Charles A. Doan, Columbus, Ohio, honor guests. (Drs. Frank J. Holroyd and W. E. Vest, in charge.)

12:15—(McLure Hotel). W. Va. Obstetrical and Gynecological Society. Dr. S. A. Cosgrove, Jersey City, N. J., honor guest. (Dr. W. E. Hoffman, in charge.)

Tuesday, May 16

12:15—(McLure Hotel). Section on Eye, Ear, Nose and Throat. Dr. Francis A. Adler, Philadelphia, Pa., honor guest. (Dr. J. S. Maxwell, in charge).

12:15—(Windsor Hotel). Sections on Internal Medicine and Pediatrics. Dr. W. W. Waddell, Charlottesville, Va., and Major Ralph H. Kunstadter, MC, Ashford General Hospital, honor guests. (Dr. James L. Wade and Dr. Andrew E. Amick, in charge.)

12:15—(McLure Hotel). Section on Surgery. Dr. Richard B. Cattell, Boston, Mass., honor guest. (Dr. J. B. Clinton, in charge.)

SCIENTIFIC EXHIBITS

Scientific Exhibits will be set up in the Riverview Room, just off the lobby, at the Windsor Hotel. The exhibits will be arranged under the supervision of the Committee on Scientific Exhibit composed of Dr. Hu Myers, Philippi, Chairman, and Drs. Fred R. Whittlesey, Morgantown, and John P. Helmick, Fairmont. The following is a complete list of the exhibits:

1. HUNTINGTON HOSPITAL SERVICE, INC., Huntington. — "Bridging America's Health Gap." Hospital and medical service plans, including a map showing the location of their headquarters in the United States and Canada.
2. DR. WALTER G. J. PUTSCHAR, Charleston.—"Lung Pathology." Exhibit of gross specimens and slides illustrating the different phases of lung pathology.
3. WEST VIRGINIA UNIVERSITY MEDICAL SCHOOL, DEPARTMENT OF PHYSIOLOGY, Morgantown. — "The Effect of Several Anesthetic Agents on the Motility of the Colon." The effect of some anesthetic agents on the motility of the colon of the barbitalized dog will be shown graphically.
4. HOPEMONT SANITARIUM, Hopemont. —"Bronchiectasis." Demonstrations of x-ray films showing bronchiectasis. Anatomical specimens removed at autopsy. Specimens of lungs removed at operation. Placards giving brief, concise information as to symptoms, etiology, incidence, classification, diagnosis, prognosis, and treatment.
5. THE WOMAN'S AUXILIARY TO THE WEST VIRGINIA STATE MEDICAL ASSOCIATION. — "Auxiliary Educational Program." Outline of educational program carried on by the Auxiliary in 1943-44 in regard to the Wagner-Murray-Dingle Bill.
6. COMMITTEE ON CANCER, WEST VIRGINIA STATE MEDICAL ASSOCIATION.—"Carcinoma of the Breast." Summary of principles of diagnosis and treatment of carcinoma of the breast. Charts showing results which can be expected when radical operation is done early.
7. STATE HYGIENIC LABORATORY, W. VA. STATE HEALTH DEPARTMENT, Charleston.—"Tropical and War-

time Diseases of Public Health Importance." Tropical and other war-time diseases which may be brought back by our armed forces in foreign fields in which they are endemic. Charts and other mediums showing malaria, amoebiasis, helminthic, and rickettsial diseases. Includes laboratory diagnosis measures with demonstrations.

8. BUREAU OF INDUSTRIAL HYGIENE, W. VA. STATE HEALTH DEPARTMENT, Charleston. — (A) "Effects of Toxins and Services of Bureau of Industrial Hygiene;" (B) "Methods of Determining Environmental Hazards." Drawing showing certain structures of the body, and by means of lights and push buttons, toxin affecting those organs. Panels giving a brief description of the services of the Bureau.

9. DIVISION OF MATERNAL AND CHILD HYGIENE, STATE DEPARTMENT OF HEALTH, Charleston.— "Maternal and Child Health." The scope of the maternal and child hygiene program will be illustrated by a poster. The Department's interest in the premature infant will be stressed. The Emergency Maternity and Infant Care Program will be explained.

10. AMERICAN MEDICAL ASSOCIATION, Chicago. — "Diseases Transmitted from Animals to Man." Transparencies and photographs showing the diseases transmitted from the cow, horse, dog, and other animals.

11. AMERICAN MEDICAL ASSOCIATION, Chicago.—"Use and Abuse of the Sulfonamides." Transparencies and charts showing the use of the various sulfonamide drugs and their shortcomings.

12. AMERICAN MEDICAL ASSOCIATION, Chicago.—"Dietary Deficiency Diseases." An exhibit from the Council on Foods and Nutrition of the A. M. A. in conjunction with the Food and Nutrition Board of the National Research Council. There are panels and charts, together with a question box and an exposition file giving additional information.

13. ST. MARY'S HOSPITAL, Huntington.— "Tumor Clinic, St. Mary's Hospital, Huntington, W. Va." Placards, pictures, charts, and pathological specimens illustrating the work of the Tumor Clinic at St. Mary's Hospital.

TECHNICAL EXHIBITS

Technical exhibits will be set up in the lobby, on the mezzanine and in the Club Room at the Windsor Hotel. The following is a list of the exhibitors with brief description of each exhibit:

A. S. ALOE COMPANY
Booth 16 (Club Room)

A. S. Aloe Company will show a cross-section of its complete line of surgical and laboratory equipment and supplies. Features will be American made stainless steel and chromium plated surgical instruments available today, and such new aids to diagnosis as the Goth set for rapid and accurate determination of the concentration of sulfonamides in the blood and the Somogyi Urine Sugar Comparator for rapid quantitative as well as qualitative urinalysis. The booth will be in charge of Fred S. Watson, West Virginia representative.

THE BORDEN COMPANY
Booth 9 (Club Room)

A cordial welcome to booth No. 9 is extended to you by the Borden Company. On display there is a distinctive line of infant formula foods—a line that has been specifically designed to supply you with formulas of flexibility such as your infant feeding practice demands. Stop by for details on BIOLAC, DRYCO, MULL-SOY, KLIM, BETA LACTOSE, MERRELL - SOULE POWDERED MILKS, and BORDEN'S SILVER COW IRRADIATED EVAPORATED MILK. Mr. Charles Hunter will be in charge.

BURROUGHS WELLCOME & CO.
Booth 10 (Club Room)

BURROUGHS WELLCOME & CO., New York, presents a representative group of fine chemicals and pharmaceutical preparations, together with new and important therapeutic agents of special interest to the medical profession.

THE COCA-COLA COMPANY
Booth 8 (Mezzanine)

Coca-Cola will be served to the delegates at the convention with the compliments of The Coca-Cola Company. Mr. J. O. Pearson, President, Coca-Cola Bottling Company, Wheelnig, will be in charge of the exhibit.

FEICK BROTHERS CO.
Booth 22 (Front Lobby)

Pittsburgh's leading surgical supply house will exhibit surgical instruments, physicians and hospital supplies, laboratory supplies, etc.

GENERAL ELECTRIC X-RAY CORPORATION
Booth 19 (Rear Lobby)

Mr. J. R. Ardit and Mr. S. L. Furches will have charge of the exhibit of General Electric X-Ray. If possible, they will have a film exhibit and the Stader splint. Mainly, they will be on hand to greet their friends and customers.

LEDERLE LABORATORIES
Booth 21 (Front Lobby)

Lederle Laboratories, Inc., will show their complete line of biologicals and pharmaceuticals in Booth 21, where Mr. Dennison Ellis and Mr. F. C. DiStefano will be in attendance. Emphasis will be placed on the various sulfonamide preparations and Polligens, the new and simplified idea in treating hay fever. Also to be shown are the complete line of globulin modified antitoxins and such items as Rhulitol and Poison Ivy Extracts.

ELI LILLY & COMPANY
Booth 20 (Rear Lobby)

The Lilly exhibit will feature an anatomical model illustrating the technics of caudal and spinal anesthesia. Lilly products will be on display, and medical service representatives will be present to assist visiting physicians in every possible way. Mr. J. T. Latham will be in charge of the display.

MEAD JOHNSON & COMPANY
Booth 4 (Mezzanine)

Servamus Fidem means We Are Keeping the Faith. Almost every physicians thinks of Mead Johnson & Company as the maker of Dextri-Maltose, Pablum, Oleum Percomorphum, and other infant diet materials—including the new precooked oatmeal cereal, Pabena. But not all physicians are aware of the many helpful services this progressive company offers physicians. A visit to Booth No. 4 will be time well spent. Mr. W. R. Yohe is the representative in charge.

McLAIN SURGICAL SUPPLY
Booth 7 (Mezzanine)

Messrs. Schwarz, Curtis, and Davis, of Wheeling, will be present to show Allison examining room equipment, Castle Sterilizers and lamps, Welch Allyn otoscopes, cystoscopes, blood pressure outfits, and a general line of supplies and drug specialties.

THE NATIONAL DRUG COMPANY
(Booth 2 (Mezzanine)

In addition to National's time-tested, Council-Accepted biologicals, newest developments in both the biological and pharmaceutical fields will be presented. Of specific interest will be Allantomide products and National's new series of multiple antigens for simultaneous immunization. Trained representatives will be available for discussion. Mr. E. W. Zeller will be in charge.

ORTHO PRODUCTS, INC.
Booth 1 (Mezzanine)

Ortho's exhibit will feature their Council-Approved products for the control of conception. Booklets, reprints, et cetera will be distributed dealing with various methods. Ask for the recently published "Studies in Human Fertility", which deals with the many aspects of fertility control. Mr. Dupont Murphey and Mr. J. Mann will be in charge.

PARKE, DAVIS & COMPANY
Booth 5 (Mezzanine)

You will find displayed at the Parke-Davis Booth many outstanding Pharmaceuticals and Biologicals. Included in this Technical Exhibit are such noteworthy products as PHEMEROL, a new type of germicide and antiseptic; ADRENALIN PREPARATIONS; MAPHARSEN; THEELIN; DESPECIATED ANTITOXINS; also other therapeutic agents of current interest. You are cordially invited to visit this Exhibit. Mr. P. N. Clayton and Mr. Charles Stevens will be in charge of the booth.

PETROGALAR LABORATORIES, INC.
Division, Wyeth, Inc.
Booth 13 (Club Room)

You are invited to visit the Petrogalar Laboratories' Booth where our representative will be pleased to suggest new uses for Petrogalar in your practice. Literature and samples are available for the asking.

PHILIP MORRIS & CO., LTD., INC.
Booth 11 (Club Room)

Philip Morris & Co. will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking. Mr. Ralph E. Hansen will be in charge of the booth.

W. B. SAUNDERS COMPANY
Booth 18 (Rear Lobby)

This publishing house will exhibit their complete line of books. Included among the new books to be shown are: Bockus' 3-volume work on "Gastroenterology," 5th edition of Christopher's "Minor Surgery," Erich & Austin's "Traumatic Injuries of Facial Bones," Hoffman's "Female Endocrinology," Moll's "Aesculapius in Latin America," Orr's 1-volume "Operative Surgery," Cecil's "Medicine," McCombs' "Internal Medicine in General Practice," Shaar & Kreuz' "External Fixation of Fractures," Lundy's "Anesthesia," Wharton's "Gynecology and Female Urology," the Military Medical and Surgical Manuals, Official U. S. Public Health Service Industrial Hygiene Manual,

Stieglitz' "Geriatrics," Weiss & English's "Psychosomatic Medicine," and many others.

SHARP & DOHME, INC.
Booth 12 (Club Room)

Sharp & Dohme will feature their new sulfonamide, Sulfamerazine, and 'Sulfasuxidine,' 'Lyovac' Normal Human Plasma, Tyrothricin Concentrate (Human), 'Depropanex,' 'Delvinal' Sodium, 'Propadrine' Hydrochloride products and 'Lyovac' Tetanus Antitoxin, Bovine. Capable, well-informed representatives will be present to welcome visitors and furnish information.

S. M. A. CORPORATION
Division, Wyeth, Inc.
Booth 15 (Club Room)

Up-to-the-minute information on Infant Feeding and Nutritional Biochemicals can be obtained at the S. M. A. Corporation booth. Of particular interest to most physicians is the new protected Vitamin A product Caritol.

VANPELT & BROWN, INC.
Booth 17 (Club Room)

You are cordially inviited to visit VanPelt & Brown's exhibit of prescription specialties. These products have been received by the medical profession enthusiastically and it is believed well worth your time to stop and interview one of the representatives who will be on hand at all times during the meeting. Mr. George J. Hulcher and Mr. W. G. Burnette will have charge of the exhibit.

WHITE LABORATORIES, INC.
Booth 6 (Mezzanine)

At the White Laboratories' booth you will find interesting copies of a series of publications under the general title "Diagnositc Aids to Vitamin Deficiency Conditions." Medical service representatives, Messrs. Rouse, Muhlbach, and Pinkerton, in attendance, will be very glad to discuss these with you. The latest clinical reports on results of the use of White's Vitamin A and D Ointment in the treatment of burns and various types of ulcers will also be available.

THE MAX WOCHER & SON CO.
Booth 3 (Mezzanine)

The Max Wocher & Son Company will show pieces from their latest Paragon style examination and treatment room suite, together with the usual line of quality instruments and sundries. Mr. L. E. Boehme will be in attendance at the booth.

JOHN WYETH AND BROTHER
Division, Wyeth, Inc.
Booth 14 (Club Room)

You are cordially invited to visit the Wyeth exhibit where Amphojel, Phosphaljel, Bepron, and B-Plex will be featured with other pharmaceutical specialties.

REPORT OF COMMITTEES

COMMITTEE ON CANCER

The West Virginia medical profession will soon be called upon to participate in the cancer control program, now being set up. Dr. Paul R. Gerhardt, Director of the new Division of Cancer Control in the State Health Department, is a practical physician of considerable experience and understands the physician's aversion to "red tape." For more than two years he was Medical Director of the State Department of Public Assistance. In this capacity he directed the cancer program, then in effect, and did it well. We may, therefore, expect from him a good administration; and he, in turn, may expect from us full cooperation.

Both Doctor Gerhardt and the medical profession are interested in seeing that the available money is spent in the interest of indigent cancer patients, and that none of it is wasted. If this is done, we may confidently go to the legislature a year hence and ask for additional appropriations.

Respectfully submitted,
J. ROSS HUNTER, M. D.,
Chairman;
RUSSELL B. BAILEY, M. D.,
CHAUNCEY B. WRIGHT, M. D.,
J. E. OFFNER, M. D.,
H. H. HAYNES, M. D.,
HU MYERS, M. D.

COMMITTEE ON INDUSTRIAL HEALTH

The Industrial Health Institutes were not held last year on account of lack of funds and other difficulties, but every effort is being made to resume the Institutes during 1944. Your committee is 100% for this program; however, it is our belief that the program should be sponsored by component medical societies. We are requesting the president of each society to appoint a committee of three members on industrial health. Their duties would be to make a survey and report the industrial health problems peculiar to their community. With the aid of the Bureau of Industrial Hygiene, and the State Medical Association's Committee on Industrial Health, they will be requested to sponsor a program that would be beneficial in solving these problems.

The Committee recommends that the following objectives of industrial medicine be recognized:

1. The industrial physician should make it clearly understood to the employee and the employer

that a physical examination to determine the mental and physical fitness of all workers is a practical method of job placement, and is invaluable to the worker in the promotion of his physical welfare and in the reduction of lost working time due to injury and illness.

2. Education of the workers in personal hygiene and accident prevention.

3. Use of facilities available through the State Health Department and the Bureau of Industrial Hygiene in furthering the program on industrial health.

An outline of the facilities available through the State Health Department and the Bureau of Industrial Hygiene is shown in the following statement which your committee has received from Dr. J. E. Offner, State Health Commissioner, and Dr. C. Scott McKinley, Director of the Bureau:

"The State Health Department is definitely interested in industrial health. It feels that this is one phase of public health and preventive medicine from which tremendous good can arise. Many of the problems encountered in industry are the same as found in community life. The services of the State Health Department are freely available to the industries for these problems the same as they are to the general population.

"Thus the Division of Communicable Diseases will be only too glad to render assistance whenever necessary. Likewise the Bureau of Venereal Diseases and the Bureau of Tuberculosis will be glad to aid in control of these specific communicable diseases.

"The Sanitary Engineering Division can help industries maintain adequate water supplies and sewage disposal systems, as well as control health hazards in cafeterias, etc.

"The Hygienic Laboratory will perform studies on isolated communicable disease cases as it does for private physicians and will also undertake surveys when feasible and after an agreement with management has been reached.

"The Public Health Nursing Service is also available to the worker and his family for general health supervision.

"The Bureau of Industrial Hygiene has been specifically set up to aid both labor and industry. Industrial hygiene, very simply defined, is the preservation and improvement of the health of the workers. This bureau has been so organized that it can aid industry and physicians with their medical programs, aid industrial nurses, and evaluate various environmental hazards such as dust, fumes, ventilation, sanitary facilities, etc.

"Inasmuch as the responsibility for handling health problems occurring in industry has been delegated to this one Bureau, such problems should be brought to the attention of the Bureau, which can in turn call upon other branches of the State Health Department for aid in reaching a solution."

Your committee proposes that the following principles in the practice of industrial medicine be endorsed by the State Medical Association:

A. That pre-employment and periodic physical examinations be made *only* by qualified medical examiners.

B. That the pre-employment examination include a Wassermann test and x-ray of lungs, when feasible, provided no publicity be given to reports.

C. That the practice of some employers of encouraging employees to return to work too soon after injury or illness, merely to produce a good attendance record, be discouraged.

D. That in smaller industrial plants, a physician should be employed who should spend at least one hour per week per 100 employees in the plant, and that a nurse be employed to spend twice as much time in such plants.

E. That steps be taken to encourage legislation whereby industrial diseases would be covered by the West Virginia State Compensation Fund.

Respectfully submitted,

E. F. GOTT, M. D.,
Chairman;
E. N. PELL, M. D.,
W. F. ROGERS, M. D.,
MAX OATES, M. D.,
J. M. COFER, M. D.,
W. E. BREWER, M. D.

LEGISLATIVE COMMITTEE

In an off year, the Legislative Committee ordinarily has no report to make. The Committee, however, has had under consideration certain legislation in 1945 affecting the medical profession and will make recommendations to the Council and House of Delegates at the Association's annual meeting in May.

Respectfully submitted,

R. O. ROGERS, M. D.,
Chairman.

COMMITTEE ON MATERNAL WELFARE

Your Committee has but a meager report to transmit to you at this time. The increased work assumed by the physicians not in the militray services has been particularly heavy in the division of maternity care.

It has not been possible to resume the refresher courses in obstetrics. The reasons for this are obvious. Your Committee is informed by the Director of the Bureau in the office of the State Health Commissioner that West Virginia statistics for births and maternal deaths are not available for any years since 1940.

Of interest to the physicians of West Virginia are the figures relating to the operation of the Emergency Maternity and Infant Care Program. This is for maternity care only:

1. Maternity cases approved from May 12, 1943, to March 1, 1944 3,694
2. Total number of enlisted men's wives authorized care during February, 1944..... 470
3. Cases completed since EMIC program started to March 1, 1944 1,617
4. West Virginia participants in the EMIC program from May 12, 1943 to March 1, 1944:
   Physicians 671
   Osteopaths 25
   Midwives 1
   Total 697

It is pertinent for your Committee to report to you that to date the Seventy-Eighth Congress has appropriated $24,200,000.00 for use by the Children's Bureau in making allotments to the several states to provide obstetric and pediatric care for the wives and infants of servicemen.

The estimate is made that 645,000 wives of enlisted men will have babies during the present fiscal year. It may be pointed out that all of these are now entitled, on request, to the benefits of the program that obtains. Approximately fifty per cent have made this request.

This gives food for thought as to what influence this feature of providing medical care under federal auspices may have in the post-war years. Especially does one reflect when it is realized that since June 7, 1924 when hospitalization was first authorized for veterans of all wars without regard to the origin of their disabilities, 1,862,965, or more than eighty per cent of all admissions, have been for the treatment of disabilities not connected with service. Over ninety-two per cent of the admissions for the fiscal year ended June 30, 1943, were on account of non-service connected disabilities. It is important to note that of the 5,132 veterans of World War II hospitalized during the year only 2,332 were under treatment for diseases or injuries determined to be of service origin.

Respectfully submitted,

JAS. R. BLOSS, M. D.,
Chairman;
M. B. WILLIAMS, M. D.,
E. F. HEISKELL, M. D.,
E. J. HUMPHREY, M. D.,
H. G. STEELE, M. D.,
W. E. HOFFMAN, M. D.

STATE P. & A. COMMITTEE

The work in which your committee on Procurement and Assignment has engaged during the past year has concerned chiefly the new 9-9-9 program for interns and residents in West Virginia hospitals. While heavy correspondence continues concerning the Procurement and Assignment classification of West Virginia doctors, discharges from military service and relocation in civilian practice, as well as the status of doctors from other states who are practicing temporarily in West Virginia, the greater part of our time has been spent in obtaining deferments for interns and residents.

West Virginia has not had a quota since 1942. However, the P. & A. Service has continued to process applications for commissions filed by doctors in this state. In some instances, at the request of doctors who wished to apply for commissions, the local committee has very reluctantly changed their classification from "essential" to "available."

Our records show that, as of April 20, 1944, 411 West Virginia doctors have been commissioned in the armed forces. This total does not include interns and residents who have entered military service during 1943 and 1944. A small number of doctors have been discharged on account of physical disabilities, and, in most cases, have returned to civilian practice. However, this has not appreciably lessened the pressure for additional doctors in certain industrial areas of the state.

During the year, we were instructed by the Central Office of P. & A. Service, at Washington, to submit the names of all doctors in West Virginia who were heretofore declared available for military service who had failed or declined to apply for commissions, and whose status remained the same. The list was compiled with the help of each of the local P. & A. Committees, which once again made a survey of the doctor population of the area within its jurisdiction. Definite action has been taken by Selective Service in several instances, and several doctors whose names appeared on the list have applied for commissions. A number of others have been rejected on account of physical disabilities.

On behalf of the State P. & A. committee, I desire to express sincere thanks to the medical officer and state director of the State Selective Service System, the personnel of the Officer Procurement Service at Columbus, and the Office of Naval Officer Procurement at Richmond, for invaluable assistance in obtaining temporary deferment for interns

and residents called for induction by local boards, and for their cooperation in the processing of commissions for our doctors during the past year.

Almost daily we are confronted with the problem of dealing with doctors from areas outside the state who insist that they be permitted to locate and practice in West Virginia, notwithstanding the fact that they cannot for various reasons be licensed in this state. The Public Health Council has consistently refused to lower the standards to permit the granting of temporary permits to doctors who cannot meet the requirements for licensure in this state. I am still of opinion that this is the proper stand for the Public Health Council to take.

Officials of the hospitals of West Virginia have been most cooperative in preparing and submitting the forms required under the new intern-resident plan for the deferment of interns or residents or obtaining an increase in the quota of residents allotted each hospital. It has been possible to obtain deferments and increased allotments in needed cases, and the entire program is being operated very successfully at this time.

I am happy to report that the "doctor shortage" situation in industrial areas of this state has improved very much in the past year. While there are still a few places where more doctors are needed, the areas involved are smaller than in May, 1943. In agricultural areas, the situation remains much the same, but as I have heretofore pointed out, this is a peacetime as well as a wartime problem.

Your committee again expresses deep appreciation to the members of local Procurement and Assignment committees for their splendid cooperation in all the matters that are so frequently referred to them for investigation, decision, and report. We are also deeply grateful to Mr. Charles Lively, Executive Secretary of the State Medical Association, and his assistant, Miss Catherine Clarkson, for invaluable aid rendered in handling the mass of detail connected with the work of this Committee.

Respectfully submitted,

ROBERT K. BUFORD, M. D.,
Chairman.

PUBLICITY COMMITTEE

The Publicity Committee has functioned in its capacity as liaison officer throughout the past year, its activities being more especially directed towards acquainting the public with the facts concerning the Wagner-Murray Bill (S. 1161).

The Committee has received splendid cooperation from component medical societies, many of which have sponsored newspaper and other publicity. The members feel that the committee could have been used to a greater degree had the Council so desired, and express their willingness at all times to discharge any additional duties that may be assigned to them by the Council.

Respectfully submitted,

JAMES L. WADE, M. D.,
Chairman;
W. W. POINT, M. D.,
C. O. POST, M. D.

SCIENTIFIC WORK COMMITTEE

The difficulties encountered in arranging a scientific program for the annual state meeting in this third year of the war have indeed been manifold. Your Committee felt that a definite effort should be made to keep the profession of the state informed as to the progress of medicine in the Army and Navy. We, therefore, elected to have a speaker from each of the services, and at this time desire to express our appreciation to the Surgeons General of the Army and Navy and their associates for their cooperation in this matter.

We also felt that a big post-war medical problem in our own state would be the treatment of malaria and possibly other tropical diseases. We desired to have a rather extensive symposium on the subject in order better to prepare the practicing physicians for this undertaking. We were unable to allot the time for a real symposium but have included what we believe will be an excellent discussion of the malarial problem-to-be.

The Committee this year was also faced with the difficulty of reducing what was normally a three-day meeting to two days. Because of the importance of the military aspects of the program at this time and the reduction in allotted space, we have been unable to have speakers representing each Section. We sincerely hope, however, that the program will be sufficiently well-balanced to meet with general approval. All formal discussions have again been eliminated. There will be a short question period following each address, and the profession is urged to interrogate the speaker as desired.

It has been with considerable reluctance that your Committee has asked many well known members of the profession to journey to our state and appear on our program this year, realizing full well

that they are already greatly overburdened. They have, however, wherever possible cooperated to the fullest extent.

Your Committee wishes to take this opportunity to thank the Chairmen of the various Sections for their splendid cooperation. We wish also especially to thank our President, Dr. Robert Reed, Jr., and our able Secretary, Mr. Charles Lively, for their untiring efforts and real help in arranging this program.

Respectfully submitted,
RICHARD D. GILL, M. D.,
Chairman;
THOMAS L. HARRIS, M. D.,
JAMES P. MCMULLEN, M. D.

OTHER REPORTS

The report of the Committee on Necrology will be made orally to the House of Delegates by the chairman, Dr. James R. Bloss, of Huntington. Besides Doctor Bloss, the committee is composed of Dr. H. R. Johnson, of Fairmont, and Dr. Chester Ogden, of Clarksburg.

The annual report of the Secretary will be prepared as of May 12 and submitted to the House of Delegates at the first session, May 15.

The report of the Treasurer, Dr. T. M. Barber, including the annual audit of the financial affairs of the Association, will be presented to the Council at the pre-convention meeting to be held at Wheeling, May 14. The financial audit was printed in the February issue of THE JOURNAL.

Reports of at least two other standing committees, not now available, will be printed in the June issue.

HEALTH SERVICE DIRECTOR AT W. V. U.

Dr. John J. Lawless, of White Sulphur Springs, has accepted appointment as director of university health service and associate professor of medicine and surgery at West Virginia University School of Medicine. He succeeds Dr. Jerome E. Andes, who has held the post since September, 1943, and who resigned on account of ill health.

ACCEPTS APPOINTMENT AT MAYO CLINIC

Dr. J. C. Hutchinson, who has been a member of the surgical staff at Grace Hospital, Welch, for several years, has accepted an appointment for the term of one year on the surgical staff at Mayo Clinic, Rochester, Minnesota.

CONVENTION PROGRAM

20th Annual Meeting

Woman's Auxiliary to the

West Virginia State Medical Association

McLURE HOTEL, WHEELING

May 15-16, 1944

HOSTESS
Woman's Auxiliary to the
Ohio County Medical Society

SUNDAY AFTERNOON
May 14

2:00—Registration ..... Lobby

MONDAY MORNING
May 15

9:00—Registration ..... Lobby
10:00—Past Presidents' Breakfast.
Hostess, Mrs. Howard Phillips, Hawthorne Court.

MONDAY AFTERNOON

1:00—Luncheon..... Wheeling Country Club
Presiding hostess, Mrs. Arley V. McCoy.
Guest Speaker—Captain W. M. Sheppe (MC) USNR—"Recent Advances in Medical Care of Naval Personnel."
Honor guests: Mrs. Eben J. Carey, National President; Dr. Robert J. Reed, Jr., President, West Virginia State Medical Association; and, Drs. Hu C. Myers, Harry V. Thomas, Russell B. Bailey, Raymond Dunn, and R. O. Rogers, members of the State Advisory Board.
3:30—Pre-Convention Board Meeting—Wheeling Country Club.
Presiding, Mrs. John P. Helmick.

TUESDAY MORNING
May 16

9:00—Registration ..... Lobby
9:30—Formal Opening of Convention.
Presiding—Mrs. John P. Helmick.
Invocation—Rev. W. E. Craig, Pastor Fourth Street Methodist Church, Wheeling.

Address of Welcome—Mrs. Andrew Wilson, Ohio County Auxiliary.
Response—Mrs. W. E. Hoffman, President, Kanawha Auxiliary.
Introduction of Guests.
Reports of Convention Committees:
General Chairman — Mrs. D. E. Greeneltch, President, Ohio County Auxiliary.
Registration and Credentials—Mrs. Russell Bond.
Roll Call.
Reading of Minutes.
Report and Recommendations of Pre-Convention Executive Board.
Formal Report of Results of the Lay-Educational Program.
Report of Treasurer.
Report of Auditing Committee.
Presentation of Budget for 1944-45.
Courtesy Resolutions.
Report of Nominating Committee—Mrs. Ralph Hogshead, Chairman.
Election of Officers.
Installation of Officers—Mrs. Eben J. Carey, National Auxiliary President.
Address of the President—Mrs. Scott A. Ford, Beckley.
In Memoriam—Mrs. E. W. Hickson, Fairmont.

TUESDAY AFTERNOON

1:00—Luncheon.....Washington Farms
Hostess, Mrs. E. M. Phillips.
3:30—Post-Convention Board Meeting.
Presiding, Mrs. Scott A. Ford.

TUESDAY EVENING

6:30—Reception.....Wheeling Country Club
Hosts, Staff Wheeling Clinic.
8:00—Victory Dinner..Wheeling Country Club

EDMUND P. WELLS IN NAVY

Edmund P. Wells, secretary of the West Virginia Tuberculosis and Health Association, with headquarters in Charleston, left the middle of April for service in the Navy. The office is in charge of Miss Gail White and Miss Norma Ullman, pending the appointment of an acting secretary.

Obituaries

DR. BENJAMIN SPOTTSWOOD PRESTON

Dr. Benjamin Spottswood Preston, 70, prominent Charleston physician died at Lewisburg, April 19, following a long illness. Dr. Preston retired from practice in 1937 after a stroke.

Dr. Preston was born at Glade Hill, Virginia, in 1874, and graduated from the College of Physicians and Surgeons of Baltimore in 1902. He was licensed in West Virginia the same year. After postgraduate courses at Rush Medical College, Harvard Medical School, London Postgraduate Association, the New England Lying-in Hospital, the Children's Diseases Division of Harvard University, and Polyclinic Medical School and Hospital, New York, he located at Charleston for the practice of his profession.

He was active in the civic life of his home community, being particularly interested in Hillcrest Sanatorium and the Union Mission. He was formerly chief of staff of Charleston General Hospital and medical director for the Kanawha County Anti-Tuberculosis League. He was a member of the Charleston Rotary Club, a Mason, and a Shriner.

Dr. Preston was made an honorary member of the Kanawha Medical Society, the West Virginia State Medical Association, and the American Medical Association in 1938, after many active years as a member. He was also a member of the Southern Medical Association. He is survived by his widow, a daughter, Mrs. L. F. Pratt, of Knoxville, Tennessee, and four brothers, Dr. D. G. Preston, of Lewisburg, Dr. John Preston and Dr. Stephen Preston, of Roanoke, Virginia, and Dr. Tate Preston, of Herndon. A son, Lt. B. Spottswood Preston, Jr., of the U. S. Marine Corps, was killed in action in the Marshall Islands in February, 1944.

DR. ARCHIBALD KENTON KESSLER

Dr. Archibald Kenton Kessler, 76, of Huntington, died in Memorial Hospital, that city, April 12, after a long illness of heart disease. Dr. Kessler was born November 16, 1867, on a farm near Fincastle, Virginia. His family moved to Greenbrier County when he was a small boy. He graduated from the University of Louisville in 1891 and located at Hominy Falls, Nicholas County. Subse-

quently, he practiced at Alderson and Hinton and then at Clarksburg, where he built the first of three hospitals which he operated during his active medical life. He disposed of his hospital at Clarksburg and spent a year in England, where he interned at Guy's Hospital, London. Thereafter, he returned to West Virginia, locating at Huntington, where he built the Kessler Hospital and Sanitarium in 1903. He subsequently sold this hospital to Dr. R. E. Vickers, who operated it as the Mount Hope Hospital. In 1913, Dr. Kessler built a new hospital in Huntington which he operated under his name until 1917, when the name was changed to the Kessler-Hatfield Hospital, Dr. Henry D. Hatfield, former governor of West Virginia at that time becoming Dr. Kessler's partner in the institution. The name was again changed in the early 1930's to Huntington Memorial Hospital.

Dr. Kessler was an ardent sportsman and served as official tournament physician at the Golden Gloves boxing matches in Huntington and accompanied the boxers to the national tournaments in Chicago and New York.

Dr. Kessler was elected to honorary membership in the Cabell County Medical Society, the West Virginia State Medical Association, and the American Medical Association in 1941, and was a past president of the Cabell County Medical Society.

He is survived by a son, Dr. A. D. Kessler, who is on the staff of the Huntington Memorial Hospital; one daughter, Mrs. Lewis Hoyt, of Huntington; and a brother, Dr. D. P. Kessler, of Weston.

WITH DOCTORS IN THE SERVICE

Lt. L. B. Gang (MC), USNR, of Huntington, writes that he is "deep in the heart of China." He says that he has seen but few Americans and no West Virginia doctors. A letter addressed to him from the office of the State Medical Association, dated December 15, 1943, did not reach him until March 1, 1944, but his reply dated March 11 was received at Charleston March 24.

* * * *

Lieutenant Marcus E. Farrell (MC), USNR, of Clarksburg, who has been stationed at Jacksonville, Florida, is now assigned to the Naval Medical School at Bethesda, Maryland.

* * * *

Dr. William P. Bradford, of Moundsville, who is serving with our armed forces overseas, has recently been promoted to the rank of Major.

* * * *

Captain John E. Echols, of Richwood, is on the staff of an evacuation hospital in England.

* * * *

Major K. M. McPherson, of Beckley, writes from England that he has recently been in touch with several doctors from West Virginia. Drs. D. L. Butterfield, of Milburn, L. H. Layman, of Holden, and Geo. L. Armbrecht, of Wheeling, are in his unit overseas. "We all enjoy reading The Journal," he says. "Many thanks for continuing to supply us with medical literature."

Lieut. (jg) John T. Jarrett, of Dunbar is assigned to the surgical staff of an aircraft carrier somewhere at sea.

* * * *

Lieut. Edward S. Phillips (MC), USNR, of Wheeling, is now in North Africa, following duty at sea and in Italy. He writes that he has addressed letters to two of our representatives in Congress, one taking a middle-of-the-road stand in his reply, and the other being outspoken against the Wagner-Murray bill. He expresses the hope that the doctors back home will take a firm and determined stand against the bill. Lieutenant Phillips has recently been promoted from Lieutenant Junior Grade to Lieutenant Senior Grade.

* * * *

Captain A. B. Bowyer, of Elkview, who is with our armed forces somewhere in Italy, in acknowledging receipt of his membership card for 1944 says: "Even though we cannot use it to much advantage here, we feel that it is another link in our connections with the practice of medicine at home. It is a help to us in going ahead with the work that we sometimes have to be doing."

Captain Bowyer reports that his organization is still living and working in tents. "The health of our officers and personnel has been excellent," he says. "In fact, it could not possibly have been any better had we been living and working under the best of conditions."

He says that The West Virginia Medical Journal is literally "devoured from cover to cover." The president's page comes first, he writes, with the With Doctors in the Service section, editorial and organization sections and scientific articles following in order.

Discussing the Wagner-Murray bill, he says, "I certainly hope that at the annual meeting at Wheeling our Association goes on record as being opposed to the bill, not only as a matter of protection to the doctors at home, but for the sake of the members who are away and unable to help with the fight."

* * * *

Major L. A. Dickerson, of Charleston, who has been in the Army since 1940, is assigned to the Medical Service School at Fort Sam Houston, Texas, where he has served since 1941 as instructor in laboratory diagnostic procedures in hematology, parasitology, serology, etc. He reports that while he never entertained any ideas of teaching, he nevertheless finds the work most interesting.

* * * *

Captain T. L. Woodford, of Belington, is now assigned to the Medical Detachment, 60th Engr. Bn., at Camp Butner, North Carolina.

Captain James S. Klumpp (MC), USNR, of Huntington, who has been in the Southwest Pacific since 1942, is now assigned to the Naval Air Station at Miami, Florida.

* * * *

Comdr. Joseph F. Rech, (MC), USNR, for many months connected with the Navy Recruiting Office in Charleston, has been assigned to a ship in the Southwest Pacific since the first of the year.

* * * *

Captain Ralph J. Jones, Jr., of Charleston, who has been in the Aleutians for several months, is assigned to the 30th Field Hospital at Camp Bowie, Brownwood, Texas.

* * * *

Captain John C. Condry, of Charleston, following a tour of American General Hospitals in England, was assigned for a course in war surgery at the British Postgraduate Medical School, in London. He writes: "I would gladly trade this for a chance to attend the meeting of the State Medical Association at Wheeling in May." He expresses the hope that the medical profession at home is organizing strong opposition to the Wagner-Murray bill.

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Lt. Richard F. Miller, of Paden City, has been transferred from Camp Mackall, N. C., to the 324th Station Hospital (Kennedy General Hospital), at Memphis, Tenn.

* * * *

Lt. Comdr. Bruce Pollock, of Charleston, former director of county health units in the state health department, is with the Navy somewhere in the Southwest Pacific.

* * * *

Major Gilbert O. Crank, MC, of Lawton, who has seen service in India, Burma and China, has been transferred home and is assigned to the Armored School at Fort Knox, Kentucky.

EYES OF WAR WORKERS SHOW NEGLECT

Eyes of war workers show the signs of widespread neglect, both past and present, according to the results of a study conducted among a group of young employees, mostly under 30 years of age, in a California aircraft factory. Premature aging and other undesirable conditions in varying degree were found in everyone examined. Approximately one-third of the group complained of ocular discomfort. —*Better Vision Institute.*

County Society News

CABELL

The subject of "Psychoneurosis," with special emphasis on the examination and treatment of psychoneurotics, was interestingly discussed by Dr. E. F. Reaser, of Huntington, and Captains Lambert and Molle, of the Army Induction Center, at the regular monthly meeting of the Cabell County Medical Society, held at the Hotel Prichard, Huntington, April 13.

A dinner meeting of the Society will be held jointly with the Huntington Dental Society, May 11, at the Hotel Prichard. Dr. Walter Irvine Hume, Associate Clinical Professor of Surgery at the University of Louisville School of Medicine, will discuss some phases of oral surgery. As Doctor Hume's paper will be of interest to both doctors and dentists, a general invitation to attend the meeting has been extended to members of these professions residing in nearby cities. Requests for dinner reservations are being handled by Dr. Hallock Moore.

COLE D. GENGE, M. D., *Secretary.*

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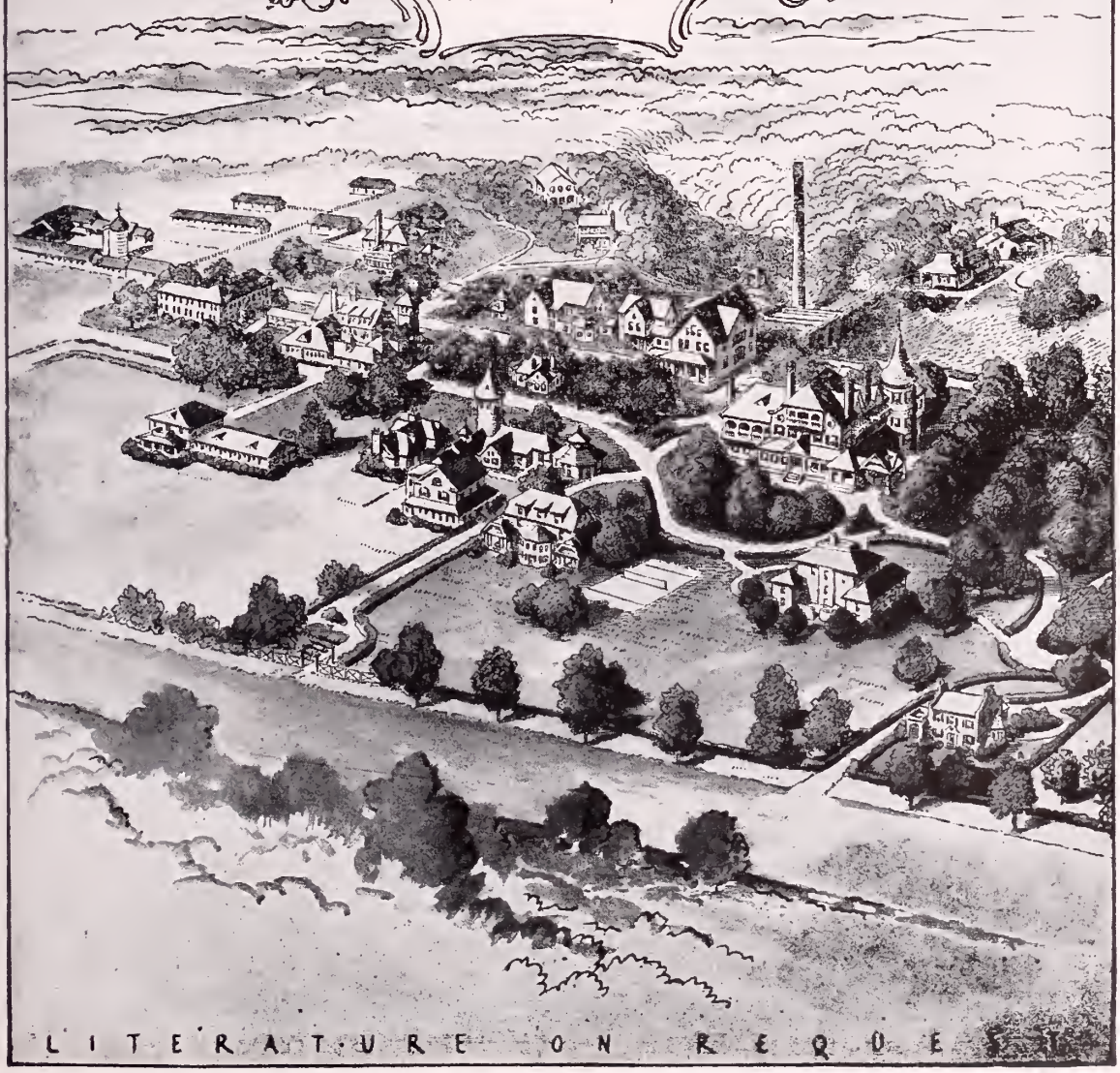

LITERATURE ON REQUEST

FAYETTE

Dr. M. W. McGehee, of Montgomery, presented a paper on "Sinusitis" at the regular monthly meeting of the Fayette County Medical Society, held at Hotel Hill, Oak Hill, March 21, which was followed by a discussion of the "Common Ailments of the Ear," by Dr. G. A. Smith, also of Montgomery.

Following the scientific program, a business session was held at which Dr. P. L. Gordon, of Powellton, was elected a member of the Society.

E. S. CARTER, JR., M. D.,
Secretary.

LOGAN

"Prostatic Malignancy" was the subject of a paper presented by Dr. Ivan R. Harwood, of Huntington, before the Logan County Medical Society at the regular monthly meeting held at the Aracoma Hotel, Logan, March 20, at 8 P. M. Doctor Harwood discussed most interestingly castration of the afflicted patient with and without supplementary estrogenic therapy.

T. H. MILLMAN, M. D.,
Secretary.

KANAWHA

Dr. M. L. White, prominent thoracic surgeon of Richmond, presented an informative and comprehensive paper on the subject of "The Problems of Bronchiectasis" at the regular monthly meeting of Kanawha Medical Society, held at the Daniel Boone Hotel, Charleston, April 11. The paper was discussed by Drs. V. L. Lance, George F. Grisinger, George P. Heffner, Andrew E. Amick, and others.

Dr. R. D. Wright, medical officer in charge of the new Kanawha Valley Health Center in South Charleston, was introduced by Dr. W. C. Stewart, president, who presided at the meeting, and presented an interesting paper on "The Hospital Treatment of Venereal Disease." The technic of rapid treatment of syphilis with mapharsen and bismuth, and the penicillin treatment of gonorrhea, were ably discussed by the speaker. The paper was discussed by Dr. E. B. Henson.

At the business meeting following the scientific program, Dr. R. J. Brown, of Charleston, was elected an honorary member of the Society.

The date of the next regular monthly meeting has been changed to Wednesday, May 10. Dr. Howard F. Root, of Boston, will speak on the sub-

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ject of "Diabetes." The meeting will be held in the auditorium at St. John's Parish House, on Quarrier Street.

W. PAUL ELKIN, M. D.,
Secretary.

MERCER

Dr. William P. Boger, of Bluefield, was the guest speaker at the regular monthly meeting of the Mercer County Medical Society, held at the Hotel West Virginian, March 16, at 8:30 P. M. His subject was "Sporadic Meningococcic Meningitis," with reports of two cases. Lederle Laboratories' motion picture, "Immunization Against Infectious Diseases," was shown at the meeting, which was well attended. A buffet supper was served at the close of the scientific program.

FRANK J. HOLROYD, M. D.,
Secretary.

OHIO COUNTY

Dr. Fred M. Jacob, Associate Professor of Dermatology and Syphilology at the University of Pittsburgh Medical School, was the guest speaker at the regular monthly meeting of the Ohio County Medical Society, at the Ohio Valley General Hospital Solarium, Wheeling, March 31. His subject was "Contact Dermatitis, with Special Reference to Occupational Dermatitis." Lantern slides were used by the speaker, and the paper was discussed by Drs. J. T. Belgrade, Howard T. Phillips, and E. N. Pell.

At a meeting of the Ohio County Medical Society, held at the Solarium of the Ohio Valley General Hospital, Wheeling, Friday evening, April 14, an interesting address on "Surgical Condition of the Large Intestine" was delivered by Dr. H. E. DeWalt, Acting Chief of Surgical Service at the Allegheny General Hospital, Pittsburgh. The paper was discussed by Drs. W. P. Sammons, R. B. Bailey, and J. R. Caldwell.

ROBT. W. W. PHILLIPS, M. D.,
Secretary.

PARKERSBURG ACADEMY

Dr. Howard T. Phillips, of Wheeling, conducted a clinic on skin at the regular monthly meeting of the Academy of Medicine of Parkersburg, held April 5 at the Camden-Clark Hospital in that city.

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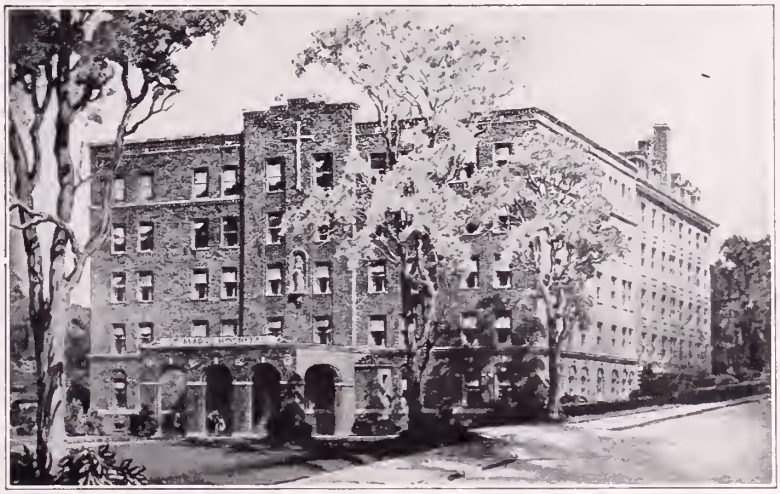

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In connection with the clinic, he delivered an interesting address on the growth of new skin.

At the same meeting, Dr. C. D. Hershey, of Wheeling, presented an interesting paper on the diagnosis and treatment of varicose veins and thrombophlebitis. The paper was discussed by Drs. Fred J. Potter, S. M. Prunty, Dana T. Moore, and R. H. Boice.

W. F. ROGERS, M. D.,
Secretary.

ICONOGRAPHY OF VITAMIN DEFICIENCIES

An "Iconography of Vitamin Deficiencies," consisting of seven unretouched color photographs revealing symptoms of vitamin deficiency cases that often go unrecognized for long periods have been reproduced and are now being circulated to the medical profession by the Winthrop Chemical Company, Inc., 170 Varick St., New York City. The pictures were originally made at the Nutrition Clinic, Hillman Hospital, Birmingham, Ala., under the supervision of Dr. Tom D. Spies, director.

All the pictures show "common pathologic changes" of riboflavin (vitamin B-2) deficiency, such as "magenta colored smooth tongue with cheilosis and thinning of the mucosa of the lips"; "acute vascularizing conjunctivitis"; "inflamed conjunctiva and invasions of vessels to edge of cornea with complete arc of anastomosis between vessels"; and "cheilosis with reddening and thinning of the lips."

ONIONS AS GERM-KILLERS

Apparent support for an old folk-belief that onions, garlic and their strong-scented kin-vegetables are "good for what ails you" is offered by the reported discovery, by Prof. B. P. Tokin of the University of Tomsk, USSR, that their essential oils contain substances that kill bacteria, protozoa and even larger organisms like yeast cells and the eggs of certain lower animals. The report is contained in a bulletin of the USSR Society for Cultural Relations with Foreign Countries, which has just been received in the United States.

Professor Tokin has given the name "phytoneides" to the substances he has isolated. Experimental use in hospitals is now being made of these compounds, particularly in the treatment of suppurative wounds.—*Science News Letter.*

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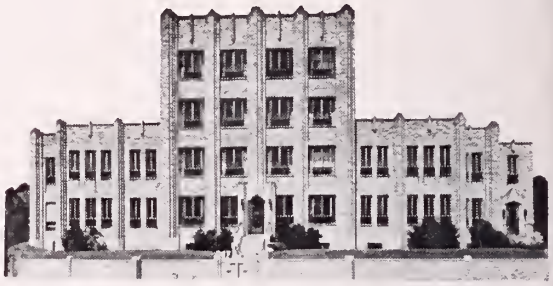

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Woman's Auxiliary

KANAWHA

At a meeting of the Woman's Auxiliary to Kanawha Medical Society, held April 11 at the residence of Mrs. G. G. Irwin, in Charleston, Mrs. Ralph McLaughlin was elected president to succeed Mrs. W. E. Hoffman, and Mrs. J. Preston Lilly was named as president elect. Other officers were elected as follows:

First vice president, Mrs. Randolph L. Anderson; second vice president, Mrs. A. C. Chandler; third vice president, Mrs. E. W. Squire; recording secretary, Mrs. J. W. Hash; corresponding secretary, Mrs. Jack Basman; and, treasurer, Mrs. T. G. Reed.

A tea in honor of the new officers will be held May 9 at the Edgewood Country Club, Charleston.

MRS. W. E. HOFFMAN,
Secretary.

McDOWELL COUNTY

Dr. A. H. Bracey, of Welch, was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the McDowell County Medical Society, held at Welch, April 12. His sub-

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ject was, "Postwar Problems Facing the Medical Profession." The speaker was introduced by Mrs. C. T. Clark, president of the Auxiliary, who presided at the meeting.

New officers were elected as follows: President, Mrs. W. R. Counts; president elect, Mrs. Arnold Wilson; first vice president, Mrs. J. H. Murry; second vice president, Mrs. A. J. Villani; secretary, Mrs. C. B. Chapman; and, treasurer, Mrs. C. F. Johnston.

Funds were ordered contributed as follows: American Red Cross, $10; Women's Field Army of the American Society for the Control of Cancer, $5; Blood Plasma Fund, $10; and, Welch Youth Center, $15.

MRS. CHAS. B. CHAPMAN,
Secretary.

RALEIGH

At a meeting of the Woman's Auxiliary to the Raleigh County Medical Society, held at the Coca-Cola Building, Beckley, April 17, the following officers were elected for 1944-45:

President, Mrs. L. E. Shrewsbury; president elect, Mrs. T. U. Vermillion; first vice president, Mrs. R. G. Broaddus; second vice president, Mrs. M. M. Ralsten; secretary, Mrs. W. C. Covey; and, treasurer, Mrs. W. C. Mays.

It was announced that Mrs. A. C. Echols, of Layland, had won $40 as first prize in Group 3 of the National Hygeia Contest.

Arrangements were made for a picnic in June in observance of Doctor's Day.

MRS. J. M. CORAM,
Secretary.

SOUTHERN MEDICAL AT ST. LOUIS

The Council of the Southern Medical Association recently selected St. Louis as the convention city for the 38th annual meeting of that organization, which will be held Nov. 13-15, 1944.

TECHNICAL EXHIBITS

Due to the heavy demand for space for technical exhibits at the Wheeling convention, it has been necessary to utilize parts of the lobby at the Windsor for this purpose. Interesting exhibits will be found in the front and rear of the lobby, on the mezzanine, and in the club room, and all members of the State Medical Association are urged to register at each of the 22 booths.

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TUBERCULOSIS ABSTRACTS

(Continued from page 147)

adhesion was awaited. Meanwhile the still unaffected cavity might supply bacilli to cause other cavities elsewhere.

Intrapleural pneumonolysis was designed to transform, where feasible, a poor pneumothorax result into a satisfactory effective collapse. Under local procaine infiltration anesthesia, a special cannula is introduced between the ribs into the pleural space, transmitting a visual instrument not unlike a cystoscope. Through this the operator views the interior and by means of a cautery inserted through a second cannula in another interspace severs the adhesions under direct vision.

Adhesions vary in size and shape and may be multiple. They range from "fiddle string" to short, thick and cylindrical, or may resemble accordion pleated sheets that radiate in all directions and run all the way from paper-thinness up to bands one or several centimeters in diameter. In using the cautery it is necessary to remember that thicker adhesions may contain lung tissue or large blood vessels and that they may be attached firmly to the aorta, subclavian artery or mediastinal structures. * * *

A skilled operator will sever an adhesion as near its parietal extremity as possible, thus protecting the lung while exercising due caution as regards the intercostal structures as well, especially if actual dissection in the latter area proves necessary. In competent hands, backed by adequate experience and judgment when and when not to cut, the operation is a minimal one as regards the patient's discomfort. In less experienced hands, however, it can present dangers exceeding those of almost any other major intrathoracic surgical procedure. * * *

Intrapleural Pneumonolysis, Lt. Comdr. J. E. Dailey, M. C., U. S. N. R., Diseases of the Chest, Nov.-Dec., 1943. (*Reviewed and passed by The Bureau of Medicine and Surgery, U. S. Navy.*)

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SHOTGUN WOUNDS OF THE ABDOMEN

By W. MERLE WARMAN, M. D.
Morgantown, West Virginia

SHOTGUN wounds of the abdomen probably differ very little from other penetrating wounds of the abdomen. During 1942, in this community, we had four such cases resulting in three deaths. The more than usual frequency of this type of wound within such a short period of time prompted me to write this article giving an account of the one surviving case and of the treatment administered.

Due to the numerous missiles producing the injury, shotgun wounds of the abdomen are usually fatal. The degree of the injury is in direct proportion to the distance between the individual and the gun when the discharge takes place. Numerous shots entering the abdomen simultaneously at close range produce fearful lacerations of the tissues. Because these wounds are lacerated, the hemorrhage from the wound itself is usually secondary rather than primary. Bits of clothing, fragments of bone, and other foreign bodies may be carried into the wound. The single shots are usually deflected from the vessels; however, if the great vessels are wounded, the case seldom reaches the surgeon. The organs most frequently damaged are the small intestine, the colon, and the stomach, and such solid organs as the liver, kidneys, and spleen. In cases of injury to the solid organs, the mortality rate is about 70 per cent, whereas in cases of injury to the hollow viscera it is about 40 per cent. The causes of death in wounds of this type are: (1) peritonitis, (2) shock, and (3) hemorrhage. With respect to time of death, the exact reverse of this order is true. In other words, early deaths are due to hemorrhage, then shock, and finally peritonitis.

THE AUTHOR

Dr. Warman, graduate University of Maryland; interned and postgraduate work, Mercy Hospital, Baltimore; staff Heiskell Memorial Hospital and Monongalia General Hospital, Morgantown.

CASE REPORT

R. L., a white male, 18 years old, was first seen in the accident room of the Heiskell Memorial Hospital, at about 6:30 p. m., on November 25, 1942. About two hours prior to admission, while rabbit hunting, he had met with an accident in which his companion fired a shotgun into his right flank. Hurried examination showed a ragged wound

about two inches in diameter, at the level of the crest of the right ilium. Through this wound could be seen the intestine (apparently cecum), and a good deal of blood was escaping through the wound. The boy complained of pain in the upper abdomen, and his face was pale. His blood pressure was 110 systolic and 70 diastolic; his pulse, 100. A large sterile pad was placed over the wound, tetanus and gas gangrene antitoxin was administered, and the patient was taken to his bed. Several donors were procured and at about 8:00 p. m., approximately four hours after the injury, the patient was taken to the operating room. Under ether anesthesia the abdomen was opened through a right paramedian incision. When the abdomen was opened, the escape of blood was so profuse that it could not be sponged away rapidly enough with gauze, and suction was added.

The first apparent injury was the ragged bony edge of the ilium which could be felt by the examining finger. Several fragments of loose bone lay in the peritoneal cavity. These were removed. In addition to these fragments of bone were numerous lead pellets, several pieces of wadding from the shell, three or four fragments of buttons, and particles of clothing. Of course, I was unable to remove many of the shot. Examination of the cecum showed that it was so lacerated, and so much of the blood supply through the mesentery destroyed, that repair was impossible. The lower end of the cecum, the appendix, and a portion of the terminal ileum, were, therefore, removed en masse. The end of the colon was closed, and the ileum anastomosed in an end to side manner. Approximately four feet up the ileum and spaced about four inches apart, were two large perforations and lacerations; the mesentery to this area had been stripped off. This section of gut was then resected, and an end to end anastomosis effected. In the upper portion of the small intestine, about four feet from the ligament of Treitz, the jejunum also had been completely severed so that the ragged edges had to be debrided and anastomosed end to end. In addition to the intestinal wounds just described were about eight large lacerations or perforations of the intestines, varying from one-half to one inch in diameter. These were closed by pursestring sutures and sutured at right angles to the long axis of the gut. Wherever possible the numerous minute perforations of the intestines and mesentery were closed with pursestring sutures. Surprisingly, there was little soiling of the peritoneal cavity with intestinal contents. Much of the foreign material, including bone, buttons, clothing, macerated muscle, etc., was removed, and at a point a few inches above the highest anastomosis, a catheter was inserted into the jejunum. After being run through a piece of omentum, this catheter was brought out through a stab wound in the left side of the abdomen. The deep rent in the lateral peritoneum, in the right flank, was sutured. Through a stab wound in the lower right side of the abdomen, two cigarette drains were then placed down to the region of the cecum, and 15 grams of sulfanilamide powder sprinkled into the peritoneal cavity. The omentum was then placed down over the intestinal loops, and the wound closed with No. 1 chromic catgut in the peritoneum and interrupted No. 2 chromic catgut in the fascia. A small rubber dam, as a drain, was placed in each end of the wound, and the skin margins approximated with a running silk suture. One silkworm gut suture was used to bring the edges of the gunshot wound together enough to check the bleeding.

During the operation the patient was given 1,500 cc. of citrated blood and 2,000 cc. of 5 per cent glucose solution.

TREATMENT

The specific case I am reporting illustrates a number of fundamental principles underlying the treatment of gunshot wounds of the abdomen, particularly those involving the intestines.

Shock in the early stages is due to hemorrhage and can be treated effectually only by stopping the bleeding. At this stage shock is in direct proportion to the amount of bleeding. The figures for this, as given by Griswold[1] are as follows: "Seventeen per cent with hemorrhage of less than 500 cc.; 40 per cent with hemorrhage of 500-1,000 cc., and 65 per cent with hemorrhage of over 1,000 cc." The first and most important step, then, is to find the bleeding point and stop the loss of blood. The blood loss must be replaced immediately by intravenous blood or plasma, and means to check the internal bleeding must be instituted at once. The other usual means to combat shock can be carried on at the same time.

The most important single means to com-

bat infection is early operation. According to formerly quoted figures, the mortality from peritonitis ranges from 15 per cent within four hours to 90 per cent after twelve hours. Conservative management hardly has a place in treatment of gunshot wounds of the abdomen. The use of sulfa drugs has doubtlessly reduced these percentages, but to what extent, I am unable to say.

The peritoneum has remarkable powers of combating infection. Of course, this power remains only when the source of infection is removed. All the perforations of the bowel must be closed. Systematic inspection of the gastro-intestinal tract from the stomach to the rectum is essential. The overlooking of one perforation may lead to fatal complications, although torn intestines do not leak widely for many hours. Contaminated peritoneum differs from frank peritonitis, and the sulfonamides aid in preventing the development of infection. The sulfonamides may be given by mouth or intravenously, and some say when thus given they are just as effective as when locally applied. The usual practice here, however, seems to be to apply the drug locally and supplement this intravenously, or by mouth. Another vital point is to control the spreading of the gastro-intestinal contents as much as possible. Material from the upper intestine does not cause such serious infection as does that from the colon. The shots being, in effect, small, scattered, foreign bodies, are not necessarily removed. Protracted search for them consumes time which might better be used in looking for damaged structures to repair. Removal of the gross contaminated material most certainly should be done, but it is useless to try to sterilize the abdominal cavity by irrigation or similar means. Mopping or gentle suction will usually remove the greater portion of foreign material. Irrigation tends to spread the contamination. Ogilvie[2] states that adequate drainage of the abdomen saves the most lives; failure to provide drainage causes many deaths. This should answer the question whether or not drainage in these grossly contaminated abdominal wounds is essential.

Small perforations of the intestines can be closed by pursestring sutures or mattress sutures at right angles to the long axis of the intestine. Where the lacerations are extensive or the blood supply has been destroyed, resection is necessary. Wise and Romansky[3] state that because of the increased mortality from multiple resections, single portions of the intestines should be removed, if it is at all possible to include all the lesions. In the same article they state that in World War I no successful triple resection of intestines was recorded. As much as one-fourth to one-half of the small bowel can be removed with safety. All wounds of the colon, particularly those of the rectum, require proximal colostomies or enterostomies. A great deal has been written on the types of colostomies, the methods of closure, etc.; but the simplest decompression enterostomy that I know of, is the one described to me by Dr. Griffith, of Mercy Hospital, Pittsburgh, Pa. The enterostomy, of course, should be placed above the injured section. This is done by inserting a small rubber catheter into the bowel through a stab wound and suturing it in place with silk. This catheter is then run through a portion of omentum (a small piece may be detached if none is available in the area) and brought out through a stab wound in the abdomen. This catheter will prevent tension on the anastomosis, or injured bowel, and decompress the proximal gut, so that feeding by mouth can be started early. After four or five days, the catheter can be removed; within twenty-four hours, or perhaps forty-eight in the case of jejunum, the small piece of omentum will heal the peritoneum, and by that time the enterostomy will be closed.

SUBSEQUENT HISTORY OF THE CASE

This patient had a stormy course. He developed some pleural effusion from atelectatic areas in the right lung, but this responded to aspirations. Figure I shows the patient several months after he left the hospital. A large ventral hernia is present

following some sloughing in the wound. On December 30, 1943, the patient was brought back for the repair of his hernia. On opening his abdomen this time I was agreeably surprised by the absence of adhesions. There was one point at which the small intestine had adhered to the abdominal wall, but this was probably the result of the catheter (enterostomy) at the previous operation. This adhesion was dissected free.

Since there has been some discussion regarding the merits of sulfathiazole and sulfanilamide powder in the abdomen, I was interested in noting the effects from sulfanilamide powder (15 grams) which one year ago had been sprinkled into this abdomen. In spite of the great amount of contamination at that time, (bits of clothing, gun wadding, intestinal contents, etc.), there was very little evidence of this trauma. The peritoneum was

Fig. I.—Patient several months after the accident. He is handicapped by this large ventral hernia. The scars of the shotgun wound and the operative scar are shown.

generally smooth and glistening throughout. The thickened peritoneum was closed by overlapping its layers and suturing with silk. The fascial layers were then imbricated and sutured with silk.

Figure II shows the patient two months after the repair of his hernia.

Zinninger[4], suggests through and through sutures of stainless steel wire, these sutures to include all structures (even the peritoneum) with the exception of the skin. He states that this allows better healing, with drainage between the sutures and relief of tension on the wound edges. This method may have prevented the herniation as illustrated in Figure I.

SUMMARY

After shock has been somewhat overcome, the treatment of patients with shotgun wounds of the abdomen consists of early operation, using routine preparation of the skin with

Fig. II.—Patient after the repair of the ventral hernia. Only one small intra-abdominal adhesion was found.

soap and water, ether and alcohol, and ether anesthesia. Gentle removal of the gross contaminating material and debridement of the gunshot wound itself are then done, followed by careful examination of the whole gastrointestinal tract from rectum to stomach, with closure of all perforations. Control of hemorrhage and replacement of blood loss are important. Continuous gastric suction is used although this does not entirely replace the temporary decompression enterostomy previously described. The sulfonamides are used locally, parenterally, and by mouth. Closure of the wound is perhaps most satisfactorily done by the use of through and through sutures of stainless steel wire.

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DIRECT BLOOD TRANSFUSION IN MODERN SURGICAL PRACTICE *

By CHARLES D. HERSHEY, M. D.
Wheeling, West Virginia

In many hospitals the sole procedure for administering blood transfusions has been by the indirect method with the addition of sodium citrate. Particularly since the advent of the blood bank, this method has been used to the exclusion of the more time-honored direct transfusion which involves the immediate transfer of blood from donor to patient without the addition of an anticoagulant. My attention recently has been drawn to certain conditions in which I believe direct transfusion is definitely indicated over the indirect type, and it is the purpose of this paper to discuss these and to present certain data relative to the administration of citrated and noncitrated blood.

It is a well recognized fact that transfusion reactions following the administration of preserved blood are common. In many cases citrated blood from a donor, if administered within a short time, may not cause reaction, but in certain individuals repeated transfusions are accompanied by deleterious manifestations. This becomes a serious problem when these patients are in immediate need of blood or when operation must be postponed until an anemia or hypoproteinemia has been corrected. Several such patients have recently come under my observation and the management of four of these will be discussed:

CASE REPORTS

H. D., suffering from ulcerative colitis, was given four transfusions of citrated blood upon separate days, and each was followed by reactions of varying severity consisting of chills, fever, and apprehension. Two direct transfusions were then given and neither produced any reaction.

A. M. entered the hospital, having been found to have a carcinoma of the cecum. As her hemoglobin was found to be only 40 per cent, she was given a transfusion of bank blood, which had to be discontinued because of the onset of severe chills and a rise in temperature to 104 F. A short time later she was given a direct transfusion without reaction.

O. S. was transferred from the medical service with the diagnosis of ulcerative colitis with sudden severe rectal hemorrhage. Shortly before his transfer to the surgical service he had been given a transfusion of bank blood which had to be discontinued because of a severe reaction. After his reactive symptoms had subsided another transfusion of bank blood was attempted, but this produced an immediate reaction with chills and temperature, the latter rising to 103.8 F., and the administration of blood was stopped. Upon the following day he was given a direct transfusion of 500 cc. of blood without reaction.

G. B. had one reaction from citrated blood, but no reaction when a direct transfusion was subsequently given.

There are four reasons advanced for reaction due to sodium citrate:

(1) The high alkalinity of the citrate.

(2) Sodium citrate increases the coagulation of blood in vivo, although its action is the opposite in vitro.

(3) Sodium citrate may precipitate calcium from the blood.

4. Nonspecific toxicity.

The intradermal injection of sodium citrate as a test to anticipate a reaction from preserved blood would only indicate a nonspecific toxicity to the solution and, therefore, is not of great value in predicting reactions.

As the value of blood transfusion in raising the hypoproteinemic state has been a subject

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of controversy, I investigated the effects of both citrated and noncitrated blood upon the plasma protein levels in surgical patients. At first a series of patients was studied in which the serum proteins were determined only in grams per cent, by the falling drop method.

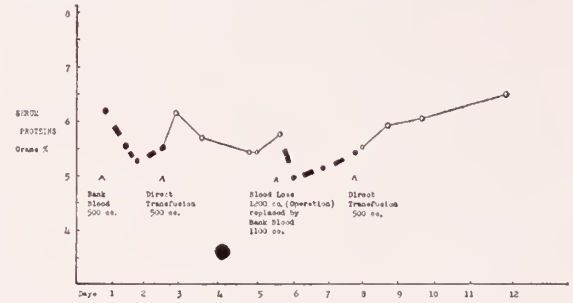

Fig. 1.—Graph showing the relative effects of indirect and direct transfusions given alternatively to the same patient upon the serum protein levels in grams %. The blood loss at time of operation (transurethral resection) was determined accurately by the colorimetric method.

The results indicated that direct transfusion might be more efficacious in this condition than indirect. Figure I shows a graph which is fairly typical for this group studied. However, such a determination failed to take into account the fluctuations in blood volume which take place following transfusion and, indeed, from day to day. Therefore, studies were carried out upon another group of patients in whom the total circulating pro-

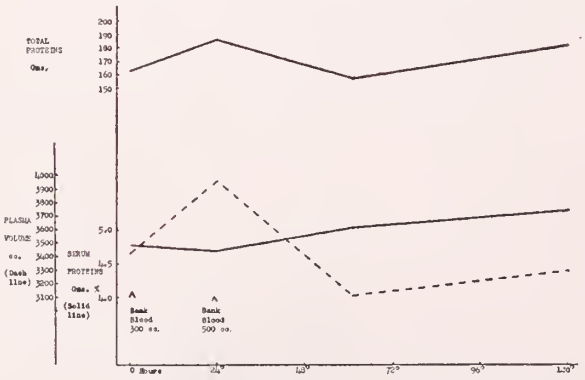

Fig. 2.—Graph showing the effect of two transfusions of bank blood upon the total circulating proteins as determined from the plasma volume and serum proteins per 100 cc. of blood.

teins were determined both before and after transfusion, determining the plasma volume by the colorimetric method using Evans blue dye, and the serum proteins in grams per cent by the falling drop method. Six patients were divided into two groups of three, bank blood being given to one group and direct transfusions to the other. The results failed to confirm the previous findings, as both groups showed an increase in total proteins following transfusion. In none of the cases was there any significant rise in

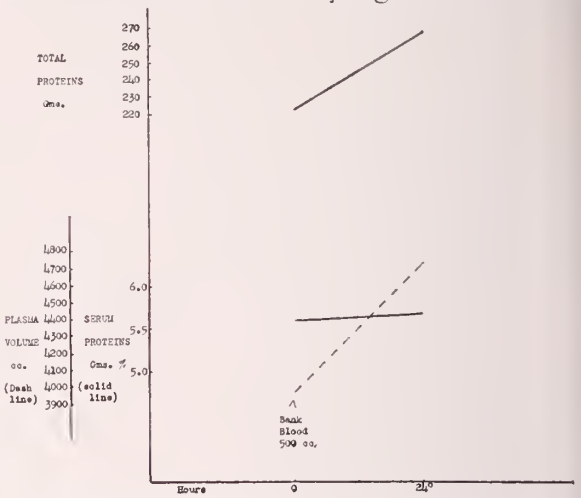

Fig. 3.—Graph showing effect of a single transfusion of bank blood upon the serum protein levels.

the proteins per 100 cc. of blood, but the increase in plasma volume revealed the rise in total proteins. As shown in Figure II, the plasma volume returns to its previous level after about forty-eight hours and the protein concentration in the blood increases.

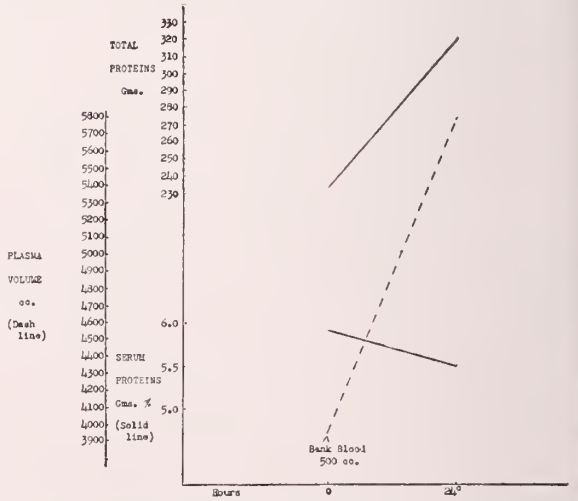

Fig. 4.—Effect of single transfusion of bank blood upon protein levels of blood. Note the drop in serum proteins per 100 cc. of blood but the rise in total proteins revealed by the great increase in blood volume.

Shearburn[1] determined the total protein levels in dogs before and after plasma transfusions and concluded that single plasma

transfusions calculated to restore the serum protein concentration of these hypoproteinemic dogs to normal were ineffective, but serum protein concentration was effectively increased by small plasma transfusions given once or twice daily. Knowing that both types of transfusions are capable of raising the plasma proteins, either method may be used for this purpose. However, in individuals showing no rise in plasma proteins after

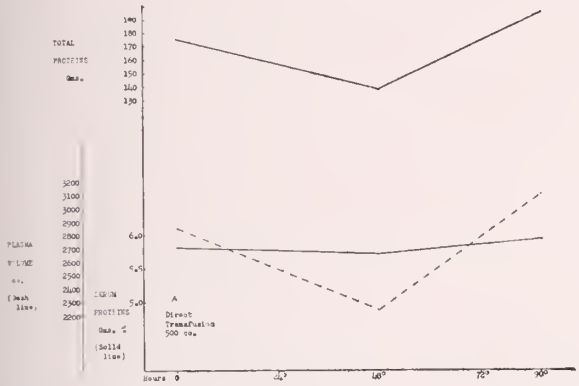

Fig. 5.—Graph showing effect of single direct transfusion of whole blood.

repeated transfusions of bank blood, I feel that direct transfusion should be employed. Indeed, Elman[2] has recently shown that there

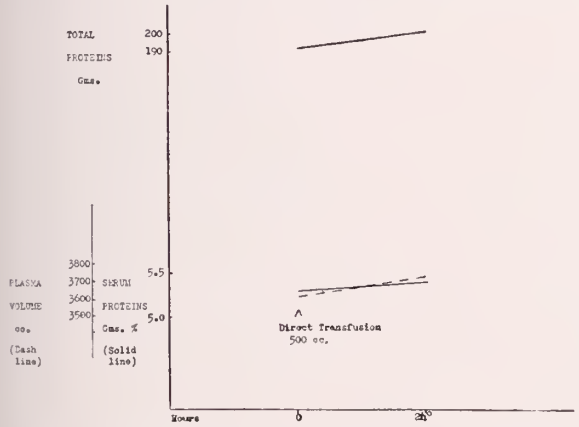

Fig. 6.—Effect of single direct transfusion of whole blood upon the blood protein levels.

is a greater increase in the protein level in the blood produced by heparinized plasma than by citrated plasma.

It has been known for some time that leucocytes are destroyed after the addition of sodium citrate and storage of blood. Drew and Scudder[3] found that polymorphonuclear leucocytes may show swelling, hazy cytoplasm, and poorly staining nuclei as early as twenty-four hours after storage, and that disintegration is extremely rapid. Strumia found that after only a few hours of contact with sodium citrate solution, locomotion and phagocytosis of neutrophils are impaired. This is also confirmed by Ravitch and Blalock[4] who found that the leucocytes decrease 50 per cent in numbers in twenty-four hours, and phagocytic activity of those remaining drops after seventy-two hours and is very slight after five days. This is well

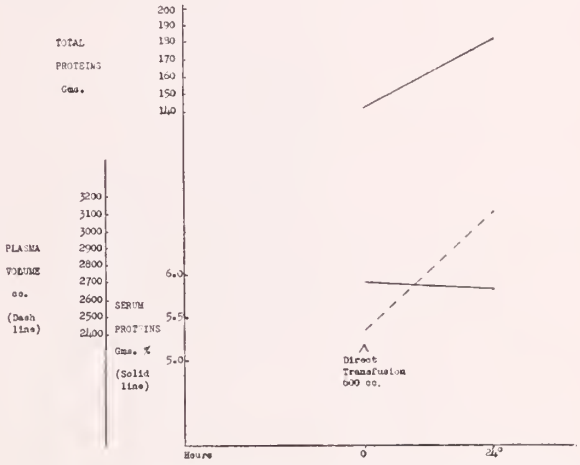

Fig. 7.—Effect of single direct transfusion upon protein levels of blood. This patient had previously had a transfusion of citrated blood with severe reaction but direct transfusion produced no reaction.

illustrated by a patient who came under my observation a short time ago. He had an acute exacerbation of a chronic osteomyelitis, and after the administration of sulfathiazole was found to be developing an agranulocytosis. The drug was discontinued immediately but the leucocyte count continued to decline. Two transfusions of bank blood were given with no effect upon the count, which decreased to 2,250 per cubic millimeter. One direct transfusion of 500 cc. was then given with the result that the leucocyte count rose to 5,000 within twelve hours and remained at normal levels thereafter.

In the light of this evidence I feel that direct transfusion is to be preferred wherever transfusion is carried out in an effort to combat an infection or to correct a leucopenia.

CONCLUSIONS

1. There are three indications for direct blood transfusion in present day medical practice:

(a) In patients who have had repeated reactions from citrated blood.

(b) In patients with hypoproteinemia who have failed to show a rise in the plasma protein level following repeated transfusions of citrated blood.

(c) Where transfusion is used in an effort to combat infection or to correct a leucopenia.

2. Both direct and indirect transfusions are capable of raising the protein level of the blood.

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AMBULATORY TREATMENT FOR SPRAINED ANKLES*

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THE disadvantages of three common methods of treatment for a sprained ankle, (bed rest, exercise, and strapping) are admittedly in both the economic and pathological order. Bed rest, as advised by Dr. Clay Ray Murray of the Columbia University College of Physicians and Surgeons as late as 1938, was certainly the lesser of two evils; simple walking on the injured part is certainly to be condemned as is the third method, that of strapping.

That there is an economic disadvantage in these treatments is quite apparent to any practicing physician, especially in these days of precious man hours. Concerning the pathological disadvantages of these methods, some further explanation is necessary.

The common pathological findings in the case of a sprained ankle are: (1) muscle spasm either at once or delayed, (2) pain either immediate or delayed, (3) venous stasis with its accompanying ecchymosis, edema, and tissue anoxia and (4) laceration of the ligaments about the ankle joint. Should the strapping method be used, there is added vasoconstriction by pressure from without. Furthermore, if simple exercise to induce increased blood flow is tried, this is defeated by the pain of weight-bearing and the pull on the injured ligament.

What is ignored too often, however, is a later disorder caused by exercise and strapping. Sending a patient back to work soon after the injury will often cause more serious and possibly chronic foot deformities such as warts, callouses, chronic traumatic arthritis, and possibly synovitis. Following are several quotations from Morton which are quite in order. "Weakness of muscles through paralysis leads to an inevitable deformity of a normally designed and evenly balanced foot." In his comments concerning the etiology of "Weak Feet", Whitman, in his book "Orthopaedic Surgery" describes the situation very aptly with the following

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statement: "The early symptoms are caused by fatigue and strain of the muscles working at a disadvantage, and the symptoms are explained by injury to which the overstrain has subjected the mechanism. Continued function during a period of acute strain leads very readily to a chronic traumatic arthritis in this part with more or less joint effusion, or synovitis. The thick and painful callosities which form in the middle of the ball of the foot are specific local reactions of the skin which are induced by the intense pressure caused by this concentration of weight." Though Professor Morton may not have been considering this pathology in connection with sprained ankles, it does seem that the quotations are in order.

Second Lieutenant John E. P., U. S. M. C.—Note the widened talocalcaneal and talonavicular joint spaces.

Because the former methods were found unsatisfactory, surgeons have been seeking some form of treatment which eliminates the disadvantages listed above. Since the early thirties, there has been an attempt made to obtain better results by the use of local anesthesia. Procaine hydrochloride in the strength of 2 per cent or less has been the favorite. Leriche, Arnulf, Murphy, McMaster, and Bakst, are but a few of the names of previous writers on this subject.

McMaster reports a series of 500 cases. He made a comparative study, treating 200 patients by the use of procaine and elastic bandage, over 200 by adhesive tape strapping, and a lesser number by bed rest, elastic bandage, and mere exercise. His results with the procaine anesthetic method were remarkably good. The only restriction in the cases treated by exercise was running or jumping.

Pfc. J. N., U. S. M. C.—Note the widened talocalcaneal joint space.

Murphy reported a series of 41 cases of which 28 had, in addition to the procaine, a modified Gibney boot; 3 had a muslin bandage; 10 had no support. He found that the best results were obtained when the hematoma could be aspirated. He reported that he had excellent results in 73 per cent of these cases.

Because there were a large number of sprains suffered as a result of running the obstacle course at the Marine Base where officers' training is carried out, it was decided to try the procaine injection treatment. When time is valuable, as it is in the concentrated period of training allowed, the ambulatory

treatment is of paramount importance if it gives good results; and good they must be, because these young officers must have no unfavorable sequelæ later. Trudging through the South Pacific jungles demands sound feet and legs.

The technique used is somewhat different from that of Murphy or McMaster. The usual x-ray picture was taken, and injection of the tender spots and aspiration of the hematoma, (if possible) were done, but for the first 20 cases no support was given and the patients were sent back to full duty including marching, running, and jumping. The remainder were given an injection in the talocalcaneal joint space, in addition.

The reason for additional injection in certain cases was that more careful x-ray studies were made in conjunction with those made at the time of injury and with reference to the amount of walking done and the onset of pain before treatment. In a review of the x-ray pictures a striking abnormality was found and appeared to be greater the longer the ankle had been subjected to trauma or strapping. Most cases showed a distinct widening of the talonavicular and cuboidal-calcaneal joint space. As has been said, the discovery led to the injecting of this space with the local anesthetic after aspiration of any blood in the joint space. Two to four cc. of the procaine was the usual injection. The results were better than in those cases where this was not done. The ache deep down in the foot and up the back of the leg noted in the first 20 cases was absent after this latter injection.

The question of danger of infection of the joint space is a pertinent one; however, in 54 cases no infections occurred. Perhaps the removal of the blood from the joint space was a factor in the prevention of infection.

The following results are presented:

Cases treated	74
Cases returning to duty at once and requiring no additional treatment	61
Cases requiring 2 days convalescence	3
Cases requiring 3 days convalescence	3
Cases requiring 4 days convalescence	1
Cases requiring 5 days convalescence	1
Cases requiring 7 days convalescence	2
Cases requiring 12 days convalescence	1
Cases requiring 15 days convalescence	1
Cases requiring indefinite period of convalescence	1

It is to be noted that the attitude of the individual patient was an important factor. The majority jumped at the chance of getting back to their training. Six wanted to "enjoy their accident" and were disappointed when no rest period was offered; of these, five improved on going back to duty after from two to six days of idleness. The sixth merely refused to cooperate and was carried on the sick list for an indefinite period.

CONCLUSIONS

1. The treatment of sprained ankles should be evaluated by consideration of both economic and pathological advantages and disadvantages of the treatment.

2. Seventy-four cases of sprained ankles were studied and treated.

3. It was discovered that the majority of cases had a widening of the talocalcaneal joint space.

4. The injection of procaine hydrochloride into the joint space mentioned above appeared to improve the already good results.

NOTE: This article has been released for publication by the Division of Publications of the Bureau of Medicine and Surgery of the United States Navy. The opinions and views set forth in this article are those of the writer and are not to be considered as reflecting the policies of the Navy Department.

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DEAFNESS*

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THERE are approximately 17,000,000 deafened people in the United States, 3,000,000 of whom are children. From 60 to 70 per cent of these children become deaf before the age of 3 and 80 per cent before they are 5 years of age.

Kinney[1] gives the percentage of occurrence of hearing impairments as follows: before or during birth, 2 per cent; the first 20 years of life, 80 per cent; the remaining years, 18 per cent.

ETIOLOGY

Group 1.—This includes heredity, congenital causes, prenatal use of drugs during pregnancy such as quinine and the salicylates, and birth injuries. Conspicuous among hereditary causes is otosclerosis which may occur at any age, even having been found in the fetus, but which usually begins around the age of 20 in young women. Syphilis is conspicuous among congenital causes, injuring or destroying the eighth nerve, the labyrinth or even the entire ear, although my experience shows the eye to be more susceptible to the ravages of syphilis than the ear.

Group 2.—Included in this group are all the exanthemata, communicable diseases, traumatism, allergy, deficiency diseases, endocrine disturbances, drugs, focal infections, and toxins, besides the triad—syphilis, cancer, and tuberculosis. Of these, epidemic cerebrospinal meningitis is the cause in 20 per cent of all adventitious deafness. Sinusitis, tonsillitis, pharyngitis, quinsy, adenoids and the common cold, associated or not with other diseases, are directly responsible for most deafness. Blowing the nose, swimming and diving are potent factors. The nasal cilia sweep backwards toward the nasopharynx, which directs us to snuff the mucus back into the throat and then expectorate it. The fact that nature has provided all animals, who pass all or some of their time in water, with a shut-off system of the eustachian tube either at the tube or in the nose, and has not so protected man, teaches him that he himself must provide this protection if he wishes to enter the water, or else stay on terra firma. Special mention must be accorded mumps in considering deafness of children.

Fowler[2] says that mumps is not primarily a suppurative inflammation—neither is the accompanying eighth nerve neuritis or labyrinthitis. The question arises: if the avenue of infection is the path of the seventh nerve, how does it happen that there is seldom a seventh nerve (facial) paralysis? One reason is that the seventh nerve is tougher than the eighth nerve. The auditory fibers are unmyelinated and are, therefore, more sensitive to poisons, anoxia, and pressure lesions. Pressure lesions in the internal auditory canal commonly irritate or paralyze the cochlea and the vestibular divisions of the eighth nerve without irritating or paralyzing the seventh nerve. Since the causative organism in mumps is probably a filtrable virus, the disease is not self-perpetuating as are diseases caused by bacterial poisons. Toxic poisoning of the eighth nerve is common; of the seventh nerve, uncommon.

Group 3.—Deafness in older persons includes the causes of the two preceding groups, together with Meniere's disease. To them may be added those incident to the declining years of life after 40 and beyond:

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arteriosclerosis, climacteric, nephritis, rheumatism, psychic causes, and the changes in general associated with senility.

The war, while producing fundamentally no different kinds of deafness, is, nevertheless, increasing deafness by leaps and bounds and at the same time accentuating various forms of deafness, to-wit: bombing deafness, from which, it is said, half the population of London is suffering; aero-otitis; and, in honor of the monumental wartime achievement of the raising of the Normandie, to say nothing of the countless other sunken craft, we might include here caisson disease. Psychoses, some of which produce psychic or hysteric deafness, are being brought into relief by the war.

DIAGNOSIS

Careful study of each case should be made, not only by the otologist, but by the internist, pediatrician, neurologist, allergist and others. Babbitt[3] feels that this basic study must include various factors in nerve damage, as suggested by Hughson,[4] acute infections with neural influence, drug poisoning, congenital influence, nutritional, vitamin and dietary imbalance, occupational hazards, endocrinopathies, hypothyroidism, dyspituitarism, and central nervous system syphilis, producing cochlear degeneration by cutting off the blood supply rather than by affecting the auditory nerve, which, supposedly, is not susceptible to the Spirocheta pallida.

Dean[5] and his associates have published a convincing thesis on allergic diseases of the ear with their special relation to labyrinthine disorder.

Mosher,[6] of Boston, has demonstrated the effect of the prenatal influence of drugs, especially quinine, on the neuro-otological perceptive apparatus. This fits in with the preventive and eugenic programs of child hygiene. The psychological factor in deafness is of great medical importance.

The nutritional index in deafened patients together with physiological and biochemical study must be made, including careful laboratory analysis of vitamin deficiency, phosphorus, cholesterol, and serum protein estimation, x-ray studies of the long bones, and basal metabolism with routine blood and urine analysis.

In the fetus, the auditory ossicles are embedded in mesoderm, which is later converted into spongy tissue and ultimately degenerates.[7] However, if it does not degenerate, it may persist throughout life as a chronic fibrous otitis media associated with progressive deafness. There are distinct anatomical differences between the newborn and the adult.

VARIATIONS IN THE NEWBORN INFANT

Kerrison[8] notes that in the newborn infant the eustachian canal presents the following marked variations from the adult type: (1) It is much shorter, measuring not more than 14 or 15 mm. (33 to 38 mm. in the adult). (2) The tympanic orifice and the caliber of the bony tube are quite as large as in the adult. The whole canal is, therefore, in proportion to its length, much wider. (3) The two portions of the tube, i.e., the membranous and the bony, are more nearly in the same straight line, so that there is no demonstrable angle at their point of junction. (4) The whole tube is nearly horizontal in direction, so that, while the pharyngeal orifice in the adult is on a lower level by 12 to 14 mm. than the tympanic orifice, it is on the same plane as the latter in the infant at term. (5) The pharyngeal mouth of the tube in the infant at term is on the same level as the hard palate, i.e., just behind the choanae, whereas in the adult it is not less than 10 mm. above the hard palate. This explains the frequency of acute suppurative otitis media in the infant and calls for sedulous examination of the ears at birth and beyond. Aside from congenital malformations such as absence of auricle, external auditory meatus, labyrinth, or absence of the whole auditory apparatus, careful examination must be made for obstructions, congestions, secretions, pus and blood. The ever present common cold must be cleared up as soon as possible; in the meantime the infant's ears must be examined carefully for the first signs of otitis media.

All children's diseases affect the ears, cerebrospinal meningitis being the greatest offender and mumps the most insidious. Trauma to children's ears is frequent from sticks, pins, stones, seeds, pencils, bugs, worms, flies, wax, molds, etc., some of which produce perforations either before or after a myringitis. In little children, mumps is thought seldom to involve the ear, but after the age of 12 it does so more often than is realized. The symptoms of involvement such as headache, elevation of temperature, tinnitus, vertigo, nystagmus, nausea, vomiting, or spastic paralysis, in various combinations, are often so slight that they are overlooked. When these symptoms are sudden and severe they are apt to be ascribed to the general bodily reaction to inflammation, to gastrointestinal disease or to meningitis and not to the auditory or static labyrinth irritation or destruction. Their severity and sequence depend largely upon the speed and extent of the lesions. Deafness usually supervenes in the second week of mumps.[2] Perceptive or nerve deafness is usually associated with loss of the higher tones, while conductive deafness involves the lower tones. In children, however, nasopharyngoscopic examination in granular pharyngitis shows an overgrowth of lymphoid tissue in and around the pharyngeal orifice of the eustachian tubes which produces chronic irritation of the tubes and middle ears, and causes impaired hearing for the tones between 10,000-16,000 double vibrations. Good hearing tones are from 250-3,000 double vibrations. These children have impairment of one octave after another toward the low end of the scale, the hearing apparatus being thus insidiously damaged for several years before such damage is recognized.[9]

HEARING TESTING

The otologist has no such precise, scientific equipment or facilities for testing hearing as has the ophthalmologist for testing vision. Witness the numerous devices at his disposal, mute evidence of the futility of them all: voice, whisper, tuning fork, monochord, Dalton's whistle, watch, acumeter, audiometer, etc. Of all these the most practical but by no means the most perfect appliance is the audiometer. Testing the baby's hearing is difficult. The cochleopalpebral test is the otologist's test while Fowler[2] finds that it is impossible to obtain quantitative results; however, after five months (sometimes earlier) one may gradually condition the baby to respond to certain sounds, such as a bell or simple call words associated with something that makes for baby's gratification—feeding or the desire for a toy, especially a toy that makes a noise.

Frequently, positive reactions may be elicited by applying a 512 or 256 vibrating tuning fork to the baby's skull. Often, if a baby is crying, he will stop crying abruptly on hearing the sound of a tuning fork before the ear or on the skull. Any difference in his reaction to a vibrating and a dead tuning fork may be noted.

THE AUDIOMETER

The audiometer is an electric instrument used by the physician for measuring hearing. It measures loss of hearing in decibels (dcb.) at calibrated frequencies (pitch) and may be compared with the retinoscope. The latter determines both degree and position of errors of refraction. The former locates both position (frequency) and degree (intensity) of loss of hearing. "Tone islands" correspond roughly to astigmatic errors of refraction and indicate the position (frequency-pitch) at which the intensity (loudness) of the hearing aid should be "peaked." Just as the trial frame enables the patient to look through the various lens combinations indicated by the retinoscope, likewise the deafened patient can actually hear through a half-dozen combinations indicated by the otologist's audiogram. Carefully worked out speech articulation tests determine the combination best suited to the individual's requirements.[10]

The audiometer is the most precise means for testing cochlear function. The cochlea is, however, only one part of the hearing mechanism. Other parts cannot be adequately

tested with the audiometer. Pure tones at normal threshold are practically nonexistent in the life of human beings. The things that do exist are speech, combinations of pure tones in music and combinations of tones in noises—all of these far above threshold. Yet we are told that we may judge of an individual's hearing by testing his ability to hear pure tones at threshold.

There are, further, a multitude of factors which influence audiometry. An individual with musical talent, innate or through training, will hear better than one with no musical ability. The power of concentration is important. A stable individual will make a far better showing than a neurotic one, disturbed by fears and doubts. I have patients whose audiometry varies 15 dcb. with rest and fatigue; others who, during and before menstruation, show over 10 dcb. variation.

Audiometry, then, although the most accurate means of testing cochlear function, is not a test of hearing in the broader sense.[11].

The ophthalmologist can actually "see the eye see", for, with his ophthalmoscope, he can see if the cornea, lens and media are clear and functioning all the way to and including the retina itself, the end organ of the optic nerve. Jones and Knudsen[12] give their idea of how to "see the ear hear" by a study of the mechanism of the middle ear, using a pneumatic oscillator with an electric otoscope. To "see the ear hear" is possible in clinical practice. We cannot observe the motion of the drum membrane when it is exposed to sound waves since it is too tiny and too rapid. The ear is wonderfully sensitive. At a frequency of 1,000 cycles a barely audible sound is heard when there is a pressure variation of only one-billionth part of atmospheric pressure in the auditory canal. At this threshold of hearing the drum membrane moves one-billionth of an inch. For lower frequencies the excursion is somewhat larger. For an ordinary sound in the office, the drum membrane moves one-millionth of an inch. We are not able to see such movements. The eye has detectors for only one octave from red to violet; double the frequencies for red are sensed as violet. In the ear there are 10 octaves, from 20 to 20,000 cycles. We cannot see such rapid movements. "How, then, can we see the ear hear?" We can at least observe the motion of the drum membrane and hammer, and to this extent we can know exactly how well this portion of the ear can hear. An oscillator with the electric otoscope causes an alternate rarefaction and condensation. We can see the drum membrane move about one-hundredth of an inch and such excursions are plainly visible. As to frequency, we can cause the membrane to move 3, 4, 5 or any number of times per second. In this sense we are then able to "see the ear hear." Stapes fixation can easily be detected in this way.

TREATMENT

Obviously, if a child is born deaf there is no treatment. The treatment of deafness, therefore, resolves itself into the realization that it is not caused by any one thing but is related to all the factors involved in growth, that is, food, water, endocrine products, electrolytes, amino acids and vitamins.

It is becoming increasingly evident that time is the great factor in the treatment of chronic progressive deafness (nerve and conduction). Physicians as well as patients must realize that if improvement is to result, treatment may have to be followed for years rather than for weeks or months, as most expect. Indeed, as in many other chronic disease states, one is fortunate if the progress of the disease can be checked. Complete cure of chronic disease is perhaps beyond the realm of probability.

Much evidence is accumulating to the effect that the time to begin the prevention of deafness is really six months before conception. Each parent should be taught that an optimum diet containing the essential food factors (vitamins) is necessary in order to beget a healthy, normal child, and that such a diet should be followed by the pregnant mother.[13].

In line with this the mother should be

treated actively all during her pregnancy for every disease with which she is or becomes infected. This includes tuberculosis and syphilis. The infant must be fed correctly from the beginning, including the proper proportions of vitamins and, if necessary, hormones, as well as actively treated for any hereditary or congenital diseases.

All children's diseases may cause deafness, including sinus infections, respiratory diseases, gastro-intestinal conditions, etc. These latter appertain also to adults and the treatment of most of them concerns the pediatrician, internist, surgeon, etc.

The otolaryngologist must treat the sinusitis, pharyngitis, tonsillitis, otitis media, mastoiditis, etc., directly, and far be it from me to analyze the multitudinous therapeutic methods used in these cases, except to remark that politzerization is not indicated as often in children as in adults, although, after an attack of acute otitis has cleared up, it is well to politzerize until all signs of conductive deafness due to adhesive otitis media have disappeared and a free tympanum presents in the child.

More attention should be paid to the proper diet in all cases and not so much to the administration of artificial vitamins. Guggenheim[11] thinks that, depending upon the degree of impairment, the dosage of thiamine hydrochloride should be from 20 to 100 mg. daily, given intramuscularly, and an additional 5 mg. three times a day, given by mouth, and that niacin in doses of 25 mg. five times a day may be given orally in addition to 25 to 50 mg. or more intramuscularly twice a day, while Shambaugh[14] takes the opposite view. Since well developed deficiency states such as beriberi, scurvy, and pellagra are not known to be associated with loss of hearing, it is unlikely that subclinical deficiencies produce nerve deafness. A review of the literature on the use of thiamine hydrochloride in the alleviation of deafness and tinnitus aurium suggests that there is no conclusive evidence in favor of the use of thiamine hydrochloride for this purpose. This is substantiated by the uniformly negative results we obtained in a series of cases of nerve deafness and tinnitus aurium in which large doses of thiamine hydrochloride were administered intravenously over a period of two weeks.

Otosclerosis is a fertile source of deafness as the focus of dystrophic bone in otosclerosis enlarges through the outgrowth of osteogenic marrow into the surrounding areas of resorption. It is now possible to influence this resorption with diet, calcium, phosphorus, and vitamins.[10]

Syphilis is greatly overrated as a cause of deafness. The treatment of aural syphilis in no wise differs from that of systemic syphilis. A word of caution must be interposed at this point in regard to all forms of treatment for deafness, because of the extreme hopefulness of these unfortunates and the psychic factors involved. Fowler[15] warns that a number of patients say they maintain better hearing on bi-weekly injections of 1 cc. of normal salt solution. At the same clinic and at the Manhattan Eye and Ear Hospital there were dozens more who thought they heard better with prostigmin, insulin, tuberculin, supplementary vitamins or operations, but properly taken multiple audiograms do not substantiate their statements.

A vast field of new endeavor, comparable with refraction of the eyes for glasses, is opening up for the otologist in the prescribing of electrical hearing aids, based upon the audiometer findings in the individual case. All persons who have a hearing loss in excess of 25 decibels (35 decibels at 4,096 cycles) throughout the range of 256 to 4,096 cycles should have a hearing aid.

For persons with purely conductive impairment an amplification at each frequency equal to the hearing loss in decibels minus 20 decibels is found to be adequate.

For persons with perceptive impairment it is generally desirable to provide more amplification for the frequencies for which the hearing losses are large than for those for which the hearing losses are small.[12]

Finally, when all treatment fails lip reading must be taught. In this connection great aid is being given nationally by the various hearing aid societies.

SURGERY

The surgical treatment of deafness is comparatively a new subject. Most of it is in the experimental stage but certain well developed otolaryngological procedures are firmly established. The deviated septum and the infection and obstruction of the eustachian tube caused by sinusitis must be eliminated. Paracentesis of the ear drum is not only a life-saving procedure, but a deafness-preventive of prime importance. This should be properly performed according to the classical method —a semicircular incision in the posterior-inferior quadrant of the ear drum, parallel with the sulcus tympanicus. The indications are: inflammation of the tympanum proper (and not a simple myringitis, which may be from an entirely external cause: wax, bugs, worms, foreign bodies, eczema, dermatitis, otomycosis, furunculosis, etc.) If one is sure that there is exudate within the middle ear, it is neither necessary nor wise to await the bulging of the posterior-superior quadrant of the drum membrane. If one can detect it by the pale yellow or amber color due to the transudate, or by a fluid level line, or niveau, paracentesis had best be done, for, while this condition tends to clear up, it is, should it persist, a fertile source of chronic fibrous otitis media, with its progressive and intractable conductive deafness.

This simple procedure, however, cannot be approached lightly, since, in the middle ear, one is dealing with the most complicated organ in the human body. Many accidents may result from ill-practiced surgery in this operation. Dislocation of the malleus or incus will produce conductive deafness; dislocation of the stapes, if not producing labyrinthitis, may result in a dead labyrinth; too deep a cut may wound the round window, or in the event of a dehiscence of the bony capsule of the promontory, may produce the same result as dislocation of the stapes. Too high a cut may wound the chorda tympani, the seventh cranial nerve, the tensor tympani muscle, the stapedius muscle, etc., with various consequences.

A hole in the drum, of itself does not produce deafness, but, conversely, a large percentage of persons with perforated drums are deafened due to intercurrent infection in an otherwise sterile cavity, the middle ear. Therefore, it behooves us to avoid a permanent perforation if possible and to work for its closure if it does occur. When a classical paracentesis is performed, repetition is seldom required. Therefore, repeated paracentesis is to be deplored. The ear drum is composed of three layers: the outer (skin); the middle (substantia propria); the inner (mucous membrane). The substantia propria maintains the integrity of the drum. It is further subdivided into two layers: the outer (radiating); the inner (circular). When this outer radiating layer of fibrous connective tissue is cut, it pulls apart and the hole remains open. However, in otitis media the drum is inflamed and there is no resiliency to these connective tissue fibers; besides, the general edema closely approximates the lips of the incision. As the otitis media heals, so does the drum and if a single incision is made the opening usually closes too. However, if the drum is cut to pieces by repeated paracentesis this healing does not take place and a permanent opening or a permanently destroyed drum is the result. Therefore, it is wise to incise the drum a single time if possible, and to watch the patient and guard him against future colds, etc., which precipitate exacerbations of the otitis media, thereby necessitating further paracentesis.

As we all know, trying to heal a perforated drum is a very difficult procedure and one that is seldom accomplished.

Tonsillectomy and adenoidectomy, due to their almost universal adoption, call for special mention. With the exception of the oxygen absorbed by the skin, every particle of food, water and oxygen that supports the entire man is ingested through the small

double portal at the anterior end of the human body, consisting of the nose and mouth. The meeting place of these two, the pharynx, is guarded by the lymphatic ring of Waldeyer, with its quadruple lock of the bilateral nasopharyngeal tonsil of Luschka; the double tubal or Gerlach's tonsil; palatine or faucial, and lingual tonsils. The location and strength of this barrier to infection within the body emphasizes its importance, standing as it does at the very beginning of the entire respiratory and alimentary systems. The routine tonsillectomy and adenoidectomy performed on all school children is an unjustifiable procedure. There are definite indications for this operation: repeated sore throats, tonsillitis, quinsy, otitis media, and sinusitis, locally; and focal infection, arthritis, rheumatism, heart involvements, tics, chorea, psychic disturbances, etc., only when it can be reasonably determined that the tonsils are the actual cause. Simple hypertrophy of the tonsil with caseous material in the crypts is no indication for operation. Regardless of how expert the operator may be, one has only to look at many a post-tonsillectomized throat: One or more pillars or the uvula may be gone; the tonsillar fossa has shrunken almost to the root of the tongue; the muscles of the pillars are gone or atrophied; the dome of the soft palate is pulled down and otherwise distorted, while the muscular wall of the nasopharynx is replaced by scar tissue, over which hangs the plug of infected mucus which streams from the sinuses above, and a large area of the throat is glazed over by scar tissue. The truth of the matter is that in spite of the uncounted numbers and the various types of operations upon tonsils, to say nothing of the multitude of instruments devised for this single operation, the ideal operative procedure has not yet been devised. No one will ever know how many potentially beautiful singing voices forever have been ruined due to the subsequent distortion of the dome of the vocal pathway by the routine tonsillectomy.

When the proper indications for a tonsillectomy are present it is an invaluable preventive measure for sinusitis, repeated sore throats, etc., and especially for chronic catarrhal and suppurative otitis media with its attendant and continued menace to hearing. These are some of the inestimable benefits to offset the bad results obtained in some cases.

Nature tries to compensate for the loss of the tonsils by causing hypertrophy and hyperplasia of the lymphoid tissue of the throat, and great masses of these follicles may be seen on the vault of the pharynx, around the orifices of the eustachian tubes, in Rosenmuller's fossæ and even in the tonsillar fossæ simulating another tonsil, even though the original has been cleanly removed. This general lymphatic mass is far harder to handle than the original tonsil, as there is no satisfactory method of treatment by surgery, cautery, chemicals, x-ray, radium, etc., since this tissue is widely disseminated over the whole area and so deeply embedded. In passing one can also mention the hypertrophied and unsightly cervical lymphatic masses that result in some cases.

MASTOIDECTOMY

Removal of the tonsils may remove the block to systemic infection causing pulmonary, gastro-intestinal, genito-urinary and other infections. These constitute a fertile source of focal infection for the upper respiratory apparatus and bring about an exacerbation of the very sinus, pharyngeal and middle ear infections with attendant deafness, a far worse condition than the original operation was designed to relieve.

Mastoidectomy, whether simple, modified or radical, has its legitimate place in the treatment of deafness, while a whole new science of the surgical treatment of otosclerosis and combined progressive deafness has been opened up.

Fowler[15] sums up these new surgical procedures thus:

1. Hughson's operation of plugging the round window is based on experimental data which have been seriously undermined by the work of Culler and his associates. Hughson

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places a fascial graft in the niche of the round window in cases of obstructive deafness.

2. Dixon's operation of placing a roll of skin in the mastoid so as to produce a secondary eustachian tube has some slight justification in experimental physiology.

3. Maurice Sourdille was stimulated many years ago by the work of Barany, who found that a fistula in the horizontal canal improved the hearing remarkably while it stayed open. Jenkins and others had demonstrated this before, but Sourdille saw the cases of Barany and his pupil, Holmgren, and went back to France where he evolved a unique technic of his own for keeping an artificial labyrinthine fenestra open and for maintaining an improvement in hearing. This technic consisted, in essence, of turning the outer surface of the medial end of the superior and posterior membranous canal wall back over a fistula in the horizontal canal.

The Julius Lempert technic used on this continent is a modification of Sourdille's. The incision is made endaurally instead of postaurally.

SUMMARY

There are millions of Americans more or less deafened, and there will be many more as a result of the present war. Deafness prevention should actually begin before birth. Prenatal care of the pregnant woman should include the proper diet, vitamins and hormones, together with active treatment for her every ill. Drugs such as quinine and the salicylates should be used with extreme caution, having in view their direct effect on the fetal ears. Trauma should be avoided at birth. After birth, sedulous examination of the baby's ears should be made throughout infancy and beyond. Proper diet, vitamins and hormones should be prescribed, and special attention to the ears should be given in the common diseases of children, and in the infectious diseases of later life, avoiding in the adult the noise-producing ear lesions, as well as trauma, and coming down to old age with its degenerative diseases and senile deafness. Otosclerosis is a eugenic problem, while conductive and perceptive deafness call, above all, for continued treatment in which time abundant is the chief consideration.

When deafness becomes permanent, hearing aids, of which the number exceeds 100, are advised. The medical profession is host to numerous parasites. A brand new one, rivaling the nonmedical refractionist is just around the corner—the audiometrist. Therefore, it behooves us as otologists to take heed of this new scientific adjunct to our profession and arm ourselves with the necessary scientific data to prescribe these hearing aids just as the ophthalmologists prescribe glasses.

Deafness is largely preventable. "Of all the senses, hearing contributes most to intelligence and knowledge," so saith Aristotle.

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Tuberculosis Abstracts

Furnished Through the Courtesy of
The West Virginia Tuberculosis Association

In cases of tuberculosis where the scales often are weighted to a precariously small degree in favor of the body, the addition of a systemic or local adverse factor may upset the balance disastrously in the direction of the disease. Such commonplace circumstances as an acute respiratory infection or an attack of measles or influenza have been observed repeatedly to be capable of ushering in an unexpected reactivation. Here are presented case records suggesting that the risk of a known tuberculous person's reaction to so simple a procedure as smallpox immunization should not be overlooked. Some of these cases may represent the operation of pure coincidence, but each of them provides the physician with reasons for observing all possible caution.

Smallpox Vaccination and Pulmonary Tuberculosis

A search of the literature gives little information regarding the possibility of vaccination for smallpox being the causative factor in a subsequent flare-up of latent or active pulmonary tuberculosis. Blacher (1931) has recorded two cases, both in children. In the first of these a boy aged 11, suffering from dystrophia adiposo-genitalis, developed a tuberculous meningitis following revaccination, and from this Blacher concluded that the vaccination had reactivated a pre-existing tuberculous focus. His second case was that of a girl aged 11, whose skiagram showed a small hard focus in the right upper zone. She was subsequently vaccinated, and ten days later there was fever and x-ray evidence of reactivation of the pulmonary lesion.

Ainger (1937) recorded two further cases where tuberculous meningitis followed immediately on vaccination, and from this he drew the conclusion that either vaccination lowered the powers of resistance, thus paving the way for a fresh infection, or that an inactive lesion already present flared up as a result of the procedure and spread unopposed throughout the lung.

Stone (1931) reported the results following the vaccination of 337 patients at the Robert Koch Hospital, St. Louis. All stages and types of pulmonary tuberculosis were included in Stone's cases, and only one patient showed any definite pulmonary exacerbation, while two others had a temporary increase in the amount of cough and sputum. His view, therefore, was that the presence of pulmonary tuberculosis was not a contraindication ot vaccination.

In the summer of 1942 there was an outbreak of smallpox in Glasgow, and later in the same year in Edinburgh and Fife. Considerable numbers of the public were vaccinated, and one of us (R. Y. K.) received numerous requests from former patients of the sanatorium for advice as to whether, in view of their previous pulmonary infection, they should undergo vaccination. Those living or working in Glasgow were advised without hesitation to be vaccinated, as it was felt that the results of smallpox would be much more disastrous than any post-vaccinal flare-up in the chest. As far as is known, none of those so advised suffered any ill-effects. Later in the year four cases were admitted to the sanatorium, all of whom gave a history of vaccination followed almost immediately by the appearance of symptoms of pulmonary tuberculosis.

Case Records

Case 1.—Male, aged 28. This man, an engineer by profession, had an excellent medical history and for years had not been off work for a single day. In June, 1942, he applied for a post abroad, and before acceptance he underwent and passed a medical examination. A condition of his appointment was that he must be vaccinated in this country before departure, and this vaccination was duly carried out by his own doctor in July. Four days following the vaccination he had a severe reaction; he felt feverish and his arm was swollen and tender. After a further three days he developed a sharp pain in the left chest, which proved to be the beginning of an acute pleurisy with effusion. The subsequent skiagram revealed bilateral infiltration with cavitation in the left upper zone. This patient stated most emphatically that prior to vaccination he had felt perfectly well and had been able to do his work, which entailed considerable physical effort, without the slightest inconvenience.

Case 2.—Male, aged 22. This boy gave a history of pulmonary tuberculosis dating from the age of 16, for which he had received sanatorium treatment on several previous ocsasions, the last being in 1939. Following this he had remained fairly well and had been living quietly at his home for two years, where his main occupation had been fishing. In July, 1942, he was vaccinated and had

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The President's Page

Well, boys, it's all over, and if I do say it myself it was a grand meeting. I would again like to thank everyone who played a part in making our 77th annual meeting a success. In spite of limited accommodations, I didn't hear any of the brethren griping beyond normal expectancy; in fact, my impression was that all seemed to be in unusually fine spirits. The program was excellent and well attended, which again proves conclusively that our Association is too small for separate sectional meetings. Many old and familiar faces were seen, but many others were not. And so for you who were unable to attend, let me say that you were thoroughly missed, but let it be our hope that before another year or two passes you will be back with us, participating in our work and pleasures as you so nobly participated not so very long ago.

You will have the opportunity to read in THE JOURNAL the scientific papers presented at the two-day session, but in addition I am sure you would like to know that transactions in the House of Delegates passed along smoothly and with decorum. We were even able to confine our old friend, Jim Bloss, to six speeches. Yes, we had a lot of fun, but at the same time many good things were accomplished for the betterment of the practice of medicine in West Virginia.

In closing, let me congratulate the members of our Association for their selection of my old friend, Tom Harris, to guide us in the troubled year that lies ahead. He knows the profession, he knows its many problems, but what's more, his help and influence will be of the greatest value when our legislature meets next year in Charleston. And now, Thomas, my boy, I extend my congratulations for the honor that has been bestowed upon you. It will bring you great happiness, but it will also cause many a restless and sleepless night. You have been given a trust. Treat it wisely and faithfully, with the best that is in you. Man can do no more.

Thanks Clarksburg, we'll be seeing you.

President.

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SEVENTY-SEVENTH ANNUAL MEETING

When the 77th annual meeting of the State Medical Association was scheduled for Wheeling, some skepticism was felt and expressed concerning the adequacy of hotel accommodations in that city. However, the Wheeling doctors promised rooms for all, and this promise was faithfully kept. While the hotels were crowded, the convention guests took slight inconveniences with a smile and went on to attend the sessions, both scientific and social, enjoying the hospitality of our Ohio county hosts.

The officers and members of the local medical society and especially the members of the committee on general arrangements, are due much praise for the success of the meeting. While entertainment was not attempted on anything like a pre-war scale, and while social activities were drastically curtailed, social hours arranged by the Ohio County Medical Society provided needed relaxation for the doctors who came to the meeting.

The Victory Dinner was a success from every angle, over 250 doctors and their wives being in attendance at this final event staged at the Wheeling Country Club.

The absence of more than 300 of our members in the armed forces was commented upon frequently, and the wish was expressed repeatedly that they could have been present. Many of these doctors were most active in the affairs of the association. They have in the past contributed much to the success of our annual meetings, and their temporary loss meant harder work for those charged with arranging plans for the convention.

Much credit is due the scientific work committee, the committee on scientific exhibits and the doctors of Ohio County generally for their help, in the face of many difficulties, in staging a meeting that was undoubtedly a huge success.

THE PRESIDENT ELECT

The selection of a president is always one of the highlights of an annual meeting. For this important office, the members of the House of Delegates of the West Virginia State Medical Association, at the 77th annual meeting at Wheeling, chose Dr. Thomas Lewis Harris, prominent surgeon of Parkersburg. Long an active member and high in the councils of the Association, this honor is well merited by Doctor Harris. His election meets with the universal approval of the members of the association and is hailed by the public generally.

The new president is known by practically all of the members of his organization. He never misses an annual meeting, and his counsel and advice are always sought in matters which in any way concern the profession. He has served as president of the Academy of Medicine of Parkersburg and as vice president of the State Medical Association. He is also an active member of the American Medical Association and invariably attends its annual sessions.

Doctor Harris has been very successful in the practice of his profession in Parkersburg. He has been a member of his local society and the state and American Medical Associations since his graduation from Jefferson

Medical College in 1912. He served as president of the West Virginia Industrial Surgeons Association in 1938-1939. During World War I, he served as a First Lieutenant in the medical corps of the army.

By temperament and by training, Doctor Harris is well equipped to discharge the duties of his new office. His statewide acquaintance is not limited to members of his own profession. He has been prominent in civic and fraternal affairs and thus counts friends by the hundreds over the state.

We congratulate Doctor Harris upon his elevation to this high office within the ranks of his profession and bespeak for him full cooperation on the part of all members in the important work that lies ahead.

MEDICAL SERVICE CENTERS

The idea of group practice in medicine is not new. Various plans are in operation over the country, and here in West Virginia we have a few notable examples of what can be accomplished in this particular field. However, the idea of group practice for all doctors is new when it is associated with a plan that seeks to provide adequate medical care for everybody.

In his presidential address, presented before the 77th annual meeting of the West Virginia State Medical Association at Wheeling, May 15, Dr. Robert J. Reed, Jr., proposed the establishment of medical service centers all over the country. These centers would be under the control of local medical societies and would provide medical service for all at the same annual rate. In addition, the indigent sick would be given the same care or treatment and the cost would be borne by the county, state, and federal government.

Under Doctor Reed's plan, all members of the local society would be eligible for membership in the group and would be expected to participate, although such participation would not, of course, be obligatory.

While there will no doubt be some who will disagree with Doctor Reed, the proposed plan certainly merits careful consideration on the part of the members of the profession. As he has pointed out, a survey recently made by the National Physicians Committee indicates that 79 per cent of the people of the United States want some easier method of meeting medical and hospital bills. Pending legislation, which has been most strenuously opposed by various professional groups, would take the practice of medicine out of the hands of the doctors and place it under the control of bureaucrats. Doctor Reed proposes full medical care for all classes of people in medical service centers operated by those best qualified by training and experience for this class of work. Unquestionably, the plan will be given close study not only by our association's fact finding and planning committee, but by similar groups throughout the country.

CONSTRUCTIVE PLANNING

The Fact Finding and Planning Committee of the West Virginia State Medical Association has done an excellent piece of work in presenting the subject of ideal legislative plans for our future governmental medical structure.

First, they urge that the whole State Health Department, including the commissioner, be freed entirely from politics and placed under the merit system. This would follow the plan now in existence in several states, notably Alabama, Connecticut, and Kentucky. The appointment and tenure of office of the State Health Commissioner would be subject to the approval of the Council of the West Virginia State Medical Association. The medical members of the Public Health Council would be appointed by the Governor from a panel submitted to him by the Council of the State Medical Association. The names on this panel would be chosen because of professional standing and attainment and without regard to political party affiliation.

Another recommendation is that the medical aspects of all the state eleemosynary institutions be under the Public Health Council, and the medical personnel of these institutions be appointed with the consent of the Public Health Council and the Council of the State Medical Association.

The proposal is made to quarantine all open cases of tuberculosis until they are no longer infectious. The wisdom of this recommendation cannot be gainsaid.

In addition to the above recommendations for our own state, the committee offers in the national field the suggestion that all the health and medical activities of the federal government, exclusive of the Army and Navy, be unified in a national department of health whose administrative head should hold the degree of doctor of medicine and have a seat in the President's Cabinet. In this the Committee follows the proposal of the American Medical Association in 1872 and often reaffirmed since then. A step in this direction has already been made by the introduction of the Miller Bill in the Federal House of Representatives, providing for the transfer of the Children's Bureau from the Department of Labor to the Public Health Service. Under this bill, industrial hygiene would likewise be transferred to the Public Health Service. Representative Miller is a physician and was formerly Health Director of Nebraska. Evidently he knows from experience the necessity for such a unification of federal health activities.

Again we want to congratulate our state medical Planning Committee on their work. They have certainly presented a forward-looking and well-thought-out plan for the integration and improvement of the legal health structure of our state government. Its adoption will mean much to our people, and will go far to make West Virginia very definitely a better place in which to live.

The greatest tuberculosis case-finding project in the history of medicine is still under way through the selective service examinations.-*Modern Hospital.*

Convention Transactions

COMMITTEE ON PRESIDENT'S MESSAGE

Bob Reed is a great optimist. This has always been evident by his cheerful disposition and his infectious laugh. And it is good now that he can see "beyond the blue horizon" a better world. Every doctor will endorse the position taken by our president that the practice of medicine is an independent enterprise and that it should remain free of any attempt at socialization on the part of the government. Unfortunately the medical profession has been too critical of innovations without substituting some constructive program of its own. Our president, for the first time, does offer a substitute plan.

For the present, the Wagner-Murray bill has no chance of being enacted into law. It is expected, however, that unless a satisfactory program is offered by the medical profession, further attempts at some form of governmental control of medicine are certain to be made. The proposal that our president has made represents an ideal approach to the solution of medical practice which covers care for the indigent sick and which the Wagner-Murray bill has missed entirely. One of the greatest defects of this bill is the failure to provide adequately for the care of the indigent.

In a profession which has been so individualistic, it is not expected that there will be universal approval of the proposed plan. This committee believes, however, that the principle is correct and offers the only solution to the medical care problem.

We particularly commend our president's message of friendship and encouragement to the many members of the West Virginia State Medical Association who are now in the service of the armed forces. We feel that we owe them every consideration on their return to their practices at home, and that the most we can do for them is too little compared with the sacrifices they have made.

We feel that the plans set forth in this address are idealistic, and to accomplish worthwhile things we must have high ideals.

We believe as our president believes that "beyond the blue horizon" we will find a better world.

F. V. LANGFITT, M. D.,
Chairman;
R. O. ROGERS, M. D.,
G. G. IRWIN, M. D.

REPORT OF EXECUTIVE SECRETARY

In my annual report to the House of Delegates in 1943, I mentioned the loss of prospective members among interns and residents who enter the military service before they have an opportunity to become identified with a component medical society. This condition still exists, and as a result, new members of the State Medical Association for the past year total but 56. However, this is an increase of 8 over the same period last year.

During the year, 30 members of our Association have died, and 26 have moved outside the state. These figures compare with 26 deaths and 29 relocations outside of West Virginia during the preceding year.

Association membership now totals 1,323, a net loss of 4 members during the year. Included in the total are 79 honorary members. As of today, 21 of the 30 component societies have reported a one hundred per cent paid up membership.

All members have paid dues with the exception of 35. Last year at this time 56 members were delinquent. The good record this year is due in no small measure to effective work on the part of secretaries and treasurers of component societies.

Each of the following societies is entitled to a place on the 1944 honor roll:

Barbour - Randolph - Tucker, Boone, Brooke, Cabell, Central West Virginia, Doddridge, Eastern Panhandle, Greenbrier Valley, Hancock, Harrison, Kanawha, Lewis, Logan, Marshall, Mercer, Monongalia, Potomac Valley, Raleigh, Summers, Taylor, Wetzel.

The following is a list of competent societies showing total membership as of May 13, 1944:

Barbour-Randolph-Tucker	46
Boone	15
Brooke	10
Cabell	117
Central West Virginia	34
Doddridge	2
Eastern Panhandle	28
Fayette	54
Greenbrier	25
Hancock	20
Harrison	86
Kanawha	211
Lewis	20
Logan	47
Marion	57
Marshall	17
Mason	5
Mercer	51
Mingo	28
Monongalia	49
McDowell	68
Ohio	96
Parkersburg	71
Potomac Valley	27
Preston	21
Raleigh	77
Summers	9
Taylor	7
Wetzel	12
Wyoming	13

A total of 414 West Virginia doctors have accepted commissions in the army or navy. These figures were compiled as of May 10, 1944. A few have been discharged from service and have returned to civilian practice. Of the total number in the service, 310 are members of the State Medical Association.

We endeavor to keep in close touch with all members who are serving in our armed forces in this country and overseas. We are constantly in communication with many of them and make every effort to keep our file of military addresses current. At this time there are probably 50 members in the service whose addresses we have not been able to obtain. However, THE JOURNAL is sent to each such member so long as we have an address.

The work of the personnel at the headquarters office is reflected somewhat in the reports of committees which have been or will be printed in THE JOURNAL.

The new Procurement and Assignment "9-9-9" program for interns and residents has required quite a little of our time. Detailed information concerning this work will be found in the report of Dr. R. K. Buford, Chairman, printed in the May, 1944, issue of THE JOURNAL.

Quite a good deal of time has also been devoted to the Association's efforts to arouse not only doctors but the people of West Virginia generally to the great dangers that lie ahead in the event the Murray-Wagner-Dingell Bill (S. 1161) should become a law. We have been joined in this fight by officers and members of our component societies and by lay groups whose members are also opposed to any class of legislation that smacks of socialized medicine. The results of this educational campaign are known to all the members, and it will suffice

now to say that six of our eight representatives in Congress are still lined up on the side of those who are opposed to the bill.

The receivers for Fidelity Assurance Association in which the State Medical Association has invested approximately $3,500, have been endeavoring to arrange the financial affairs of the corporation so that complete liquidation may be possible at an early date. I am happy to state that announcement was made on Sunday, May 14, that a 60 percent dividend has been allowed on claims of contract holders. The basis of the amount of the allowed claim is the cash surrender value on each contract as of April 11, 1941, the date receivers were appointed.

From information furnished by the receivers, it still appears probable that creditors will eventually receive from eighty to ninety per cent of the cash surrender value of their contracts.

The overall picture of the Association's finances is set forth fully in the annual audit which was presented to the Council, May 14 by Dr. T. M. Barber, treasurer. This audit was printed in its entirety in the February, 1944, issue of THE JOURNAL.

I wish to express my deep and sincere appreciation to all the officers and councillors of the State Medical Association and to the officers and members of the component societies for their continued cooperation during the past year. This cooperation has been accorded willingly and generously in the face of difficult times, heavier burdens and additional duties occasioned by the war.

Respectfully submitted,

CHARLES LIVELY,
Executive Secretary.

SYPHILIS ADVISORY COMMITTEE

A meeting of the Syphilis Advisory Committee was held Thursday morning, April 20, 1944, in the offices of the State Health Commissioner at Charleston, and at the Kanawha Valley Medical Center, South Charleston on the afternoon of the same day. The meeting was attended by Dr. C. A. Hoffman, Chairman, Huntington; and Drs. M. L. Bonar, Charleston; H. T. Phillips, Wheeling, and J. E. Offner, State Health Commissioner. The acting director of the bureau of venereal diseases and several members of Dr. Offner's staff also attended the meeting.

Following a brief review of the business transacted at the previous meeting of the Committee, the current state health department's venereal disease control program was discussed with particular reference to the reorganization of the treatment schedules for syphilis. On March 6, 1944, the state health department, in cooperation with the U. S. Public Health Service, established at South Charleston a free venereal disease hospital for contagious cases.

All treatment schedules for early syphilis in the free clinics were changed in such fashion that all infectious or potentially infectious cases were referred by city and county health officers to the Kanawha Valley Medical Center where several forms of rapid treatment were administered, instead of the routine cooperative clinical group schedules followed prior to that date.

The reorganization was made necessary due to the fact that approximately three of every four patients admitted to city and county clinics for primary or secondary syphilis failed to continue under treatment for a sufficient length of time to insure permanent noninfectiousness. Under the new method of treating such cases, through the referral to the Kanawha Valley Medical Center, it is hoped that approximately 85 percent of the cases admitted will receive sufficient treatment to insure permanent noninfectiousness.

A tour of inspection of the Kanawha Valley Medical Center was made and treatment methods and schemes were observed. This hospital also receives and treats with penicillin sulfathiazole-resistant cases of gonorrhea. In addition to the foregoing, Dr. J. E. Offner, the state health commissioner, recommended that a plan be considered whereby members of the syphilis advisory committee would serve individually at their convenience as consultants to health officers or directors in some of the larger city or county venereal disease clinics. Members of the committee would once or twice annually visit and inspect some of the larger V.D. clinics. They would also give technical advice to attending physicians, if desired, regarding diagnostic, treatment and management methods.

As consultants, committee members could also serve to effect a greater degree of cooperation between private and official medical agencies in the various communities in which they serve as consultants. The state health department would provide actual traveling expenses and a per diem allowance amounting to approximately $10.00. It would

appear that the plan of the state health commissioner has some merit, and the proposal is now being considered by the members of the committee.

The committee respectfully suggests that in the future the syphilis advisory committee be composed of members whose effective dates of appointment be staggered so that not more than one member would be lost each year. Such a procedure would permit a four-year tenure of office and would thereby make possible more effective work by the committee. The public health venereal disease control program is at the present time one of the major issues in public health work, and in order for the syphilis advisory committee to serve effectively, the longer tenure of office suggested for the members is considered desirable and necessary.

C. A. HOFFMAN, M. D.,
Chairman.

NECROLOGY REPORT

Earl Welborn Owen, Spencer.....May 17, 1943
Dorsey C. Peck, Grafton.....June 15, 1943
Thomas D. Burgess, Williamson...June 24, 1943
Harriet B. Jones, Glendale.....June 28, 1943
William H. McCauley, Sutton.....July 2, 1943
Adam McClintic Byrd, Bluefield....July 4, 1943
James T. Baker, Huntington.....July 20, 1943
Samuel Austin Daniel, Welch.....July 20, 1943
Chester Arthur Fleger, Ansted.....July 22, 1943
Cyrus H. Maxwell, Morgantown...July 25, 1943
Frederick F. Holroyd, Princeton.August 15, 1943
B. O. Robinson, Parkersburg....October 4, 1943
Uriah H. Hannah, Cass.....October 8, 1943
Ralph Hogshead, Mammoth....October 9, 1943
Jesse S. Maloy, Shinnston....November 21, 1943
A. G. Wilkinson, Wayne....November 29, 1943
E. H. Douglas, Petroleum...December 28, 1943
Jay Randolph Crawley, Anjean.February 2, 1944
Charles Benton Marshall, Nitro.February 5, 1944
Clayton C. Carson, Gassaway..February 14, 1944
David Beale Ealy, Moundsville.February 24, 1944
F. T. Scanlon, Morgantown...February 25, 1944
H. L. Goodman, Ronceverte...February 28, 1944
Erra Delafield Stump, Charleston..March 1, 1944
Samuel Cecil Austin, Charleston..March 11, 1944
Archibald K. Kessler, Huntington..April 12, 1944
Benjamin S. Preston, Charleston..April 19, 1944
Harry Howard Bolton, Thomas...April 22, 1944
Paul Douglas Hayman, Huntington..May 1, 1944
Marion Henderson Powers, Weirton.May 4, 1944

Requiescat in Pace.

Respectfully submitted,
JAMES R. BLOSS, M. D.,
Chairman;
H. R. JOHNSON, M. D.,
CHESTER R. OGDEN, M. D.

RESERVE COMMISSIONS IN USPHS

An agreement was entered into several months ago between the Procurement and Assignment Service and the Public Health Service by which doctors in private practice may be commissioned for civilian defense duty in emergency hospitals. Under this program, the following additional West Virginia doctors have been commissioned in the Reserve Corps of the USPHS (inactive status):

D. N. Barber, T. M. Barber, and John E. Cannaday, Charleston; Hilmar R. Schmidt, Elkins; Ray Charles Otte, Wellsburg; and, Charles H. Clovis, Edward N. Pell, Jr., Robt. J. Reed, Jr., and Mayes B. Williams, Wheeling.

PISTOL-PACKIN' NURSES

Through one of science's latest achievements in this war, Navy nurses are now a kind of "pistol-packin' mama."

The pistols they have been equipped with are perhaps a forerunner of a future ray pistol such as Buck Rogers of the funnies uses in his interplanetary flights. Designed for healing, they are electric and air-cooled, and shoot ultra-violet rays.

Actually, the pistols are miniature ultra-violet ray lamps for use in treating slow-healing wounds, abscesses, ulcers and certain skin diseases. In spite of their tiny size, the pistol lamps will redden the skin in one minute.

The burner is a transparent quartz tube in which the source of the rays is contained. The entire "apparatus" measures but three inches in diameter and is only ten and one-half inches long.---*New York State Journal of Medicine.*

Even with the present and comparatively low rates of tuberculosis mortality prevailing these days, it is estimated that in the entire world tuberculosis still causes more than two million deaths in a single year.---Godias Drolet in *Clinical Tuberculosis*, edited by Benjamin Goldberg, M. D., 1942.

General News

STATE MEDICAL ASSOCIATION ELECTS DR. THOMAS L. HARRIS PRESIDENT

Dr. Thomas L. Harris of Parkersburg was elected president of the West Virginia State Medical Association at the 77th annual meeting held at Wheeling, May 15-16, 1944. Other officers were elected as follows: First vice president, Dr. M. B. Williams, Wheeling; second vice president, Dr. L. G. Houser, Beckley; treasurer, Dr. T. M. Barber, Charleston (reelected); A. M. A. Delegate, Dr. W. E. Vest, Huntington (reelected); Alternate A. M. A. Delegate, Dr. W. P. Black, Charleston (reelected).

Councillors were elected as follows: First District, Dr. John P. Helmick, Fairmont, to succeed Dr. J. B. Clinton; Second District, Dr. Guy H. Michael, Parsons (reelected); Third District, Dr. J. E. Wilson, Clarksburg, to succeed Dr. C. O. Post; Fourth District, Dr. Curtis P. Artz, Grantsville, to succeed Dr. James L. Wade; Fifth District, Dr. J. L. Patterson, Holden, to succeed Dr. Frank J. Holroyd; and Sixth District, Dr. Thomas G. Reed, Charleston, to succeed Dr. Andrew E. Amick. The only outgoing councillor eligible to succeed himself was Dr. Guy H. Michael, and he was reelected for the term of two years.

Dr. Thos. L. Harris, President Elect

All of the elected officers will take office January 1, 1945.

Scientific Work Committee

Immediately after his election, Doctor Harris nominated a Scientific Work (Program) Committee as follows: Dr. James L. Wade, Parkersburg, Chairman; and Drs. Hampton St. Clair, Bluefield, and Frank V. Langfitt, Clarksburg. These nominations were confirmed by the House of Delegates, effective immediately.

Maternal and Child Welfare

The present members of the Committees on Maternal Welfare and Child Welfare were continued in office until the annual meeting in 1945.

Revision of By-Laws

At the first session of the House of Delegates, Dr. J. Howard Anderson submitted a report from the special committee on the revision of the Constitution and By-Laws. The other two members of the committee are Dr. James L. Wade, of Parkersburg and Dr. Frank C. Hodges, of Huntington. The report was amended and adopted and will be printed in two issues of the JOURNAL prior to the next meeting of the House of Delegates. The amendments to the By-Laws as approved are now in effect, but the amendments to the Constitution will not be acted upon finally until the annual meeting in 1945.

Fact Finding and Planning Committee

Dr. Ray M. Bobbitt submitted the report of the Fact Finding and Planning Committee as approved by the Council on Sunday. The report was debated and consideration carried over to a recessed session, which was held at 10 P. M., Monday evening. Recommendations of the committee, with slight amendments by the House of Delegates, were finally approved as follows:

"We are in full accord with anything that contributes to the war effort, and we are especially concerned with any project which aims at taking better care of soldiers' dependents. We are advised, however, that considerable dissatisfaction exists in some areas over the management and distribution of emergency maternal and infant care funds. We wish to suggest that each participating doctor so affected report any such dissatisfaction to the Fact Finding and Planning Committee through his local medical society. This committee, with the help of the advisory committee on maternal and child welfare will endeavor to correct any of the present methods used in this program that create confusion and misunderstandings.

"We recommend further that the House of Delegates go on record as approving a federal Department of Health, the administrative officer of which must hold the degree of Doctor of Medicine, and which such officer should have a seat in the President's cabinet. We further recommend that all federal health activities except medical services in the army and navy be administered in this department.

"We recommend and approve the establishment by the American Medical Association of a Bureau of Public Relations at Washington.

"We recommend that the House of Delegates go on record as favoring legislation which will make the appointment and tenure of office of the State Health Commissioner subject to the approval of the Council of the State Medical Association; that the medical personnel of the Public Health Council be appointed from a panel recommended by the Council; and that the appointment of medical superintendents of all state eleemosynary institutions be subject to the approval of the Public Health Council and the Council of the West Virginia State Medical Association.

"We recommend that the House of Delegates go on record again as favoring the principle of the quarantine of all cases of communicable tuberculosis.

"We recommend that the House of Delegates go on record as approving a full time health unit for each county or group of counties in West Virginia to be operated under the direction of the State Health Department. And we further recommend that all city health departments be merged with the health department of the county in which the unit is located."

Report of Council

Dr. R. J. Wilkinson, Huntington, Chairman of the Council, submitted a report from that body, unanimously approving the report and recommendations of the Fact Finding and Planning Committee, and also unanimously approving the proposed amendments to the constitution and by-laws. He further reported that the Council had directed him to recommend the levying of a special assessment of $5.00 per member to be collected in 1945 for the purpose of defraying the running expenses of the Association. Afterwards, the House of Delegates unanimously directed that a special assessment of $5.00 be levied for the year 1945.

Otologic Program

The House of Delegates went on record as approving an otologic program for the conservation of hearing among school children, and endorsed the program initiated by the American Academy of Ophthalmology and Otolaryngology for the same purpose.

Civilian Defense Equipment

The House authorized any component society to appoint a committee to take over at the end of the war, with the approval of the government, the emergency medical defense equipment of the Office of Civilian Defense, furnished by the government, and now located in various areas in West Virginia.

Resolutions

A resolution presented by Dr. Guy H. Michael, extending thanks to the National Physicians' Committee for its careful study of the medical situation in the United States, for its educational activities, and for its opposition to S. 1161, was unanimously adopted.

Dr. Frank J. Holroyd presented a resolution extending the thanks of the association to all members of the medical, dental, nursing, pharmaceutical and law associations for "valiant, strenuous, and efficient services rendered in the fight against the Wagner-Murray-Dingell bill." The thanks of the Association were also extended to the members of the Woman's Auxiliary of the county, state and American Medical Association for splendid work in opposition to the bill. This resolution was unanimously adopted.

A resolution presented by Dr. James L. Wade, thanking the Associated Press, the United Press, the Wheeling Intelligencer and the News-Register, for "extremely courteous and factual reporting of the transactions and other features of this annual meeting," was also adopted.

President's Charm

The annual award of the President's charm was made to Dr. Robert J. Reed, Jr., by Dr. R. J. Wilkinson, immediate past president and chairman of the Council.

1945 Convention Site

Invitations were extended by four component societies for the 78th annual meeting in 1945, viz., Harrison County (Clarksburg); Cabell County (Huntington); The Academy of Medicine of Parkersburg; and Monongalia County (Morgantown.) By a standing vote, the House of Delegates selected Clarksburg for the meeting. The date will be fixed by the Council later on in the year.

CONVENTION REGISTRATION

The following is a copy of the official registration of West Virginia doctors at the annual meeting at Wheeling, May 15-16, 1944:

George W. Abersold, Wheeling; Andrew E. Amick, Charleston; J. Howard Anderson, Hemphill; Randolph L. Anderson, Charleston; Harvey M. Andrew, Weston; Norman G. Angstadt, Charleston; Robert J. Armbrecht, Wheeling; Jerome C. Arnett, Rowlesburg; Curtis P. Artz, Grantsville; Robert A. Ashworth, Moundsville; Russell B. Bailey, Wheeling; T. M. Barber, Charleston; William F. Beckner, Huntington; Herbert M. Beddow,

Charleston; Joseph T. Belgrade, Wheeling; Don S. Benson, Moundsville.

E. S. Bippus, Wheeling; W. F. Bittinger, Summerlee; W. P. Black, Charleston; James R. Bloss, Huntington; E. C. Blum, New Martinsville; Ray Maxwell Bobbitt, Huntington; Meyer Bogarad, Weirton; Ralph H. Boice, Parkersburg; Russell C. Bond, Wheeling; James M. Bonnar, Fairmont; A. Spates Brady, Jr., Charleston; B. S. Brake, Clarksburg; Wayne Bronaugh, Parkersburg; Robert K. Buford, Charleston; S. M. Bull, Spencer; W. E. Bundy, Minden; A. K. Butler, Hopemont.

W. C. Camp, Spencer; J. R. Caldwell, Wheeling; John E. Cannaday, Charleston; J. W. Carney, Logan; J. Marshall Carter, Glen Ferris; Lenore Patrick Chipman, Charleston; James B. Clinton, Fairmont; E. E. Clovis, Wheeling; J. M. Cofer, Bergoo; O. T. Coffield, Wheeling; Orva Conley, Parkersburg; H. B. Copeland, Wheeling; Lloyd E. Cox, Charleston; W. A. Cracraft, Wheeling; W. H. Cunningham, Beckley.

Ross P. Daniel, Beckley; A. Morgan Dearman, Parkersburg; L. W. Deeds, Buckhannon; Charles F. Dent, Morgantown; J. M. DePue, Spencer; William S. Dick, Parkersburg; N. H. Dyer, Bartley; W. Paul Elkin, Charleston; H. P. Evans, Keystone; Louis B. Farri, Wheeling; Ivan Fawcett, Wheeling; C. C. Fenton, Morgantown; J. E. Fisher, New Cumberland; S. A. Ford, Beckley; W. B. Forman, Buckhannon.

M. Gaydosh, Wheeling; Paul Robert Gerhardt, Charleston; Richard D. Gill, Wheeling; John W. Gilmore, Wheeling; Earl F. Glass, Wheeling; Walter Glenn, Wheeling; Lt. J. R. Godbey (MC) USNR, Charleston; George F. Grisinger, Charleston; W. T. Gocke, Clarksburg; A. T. Gordon, Spencer; D. E. Greeneltch, Wheeling; R. B. Grimm, Cameron; J. A. Guthrie, Huntington; N. L. Haislip, Wheeling; Cmdr. Peter A. Haley (MC) USNR, Charleston; L. M. Halloran, Beckley; D. D. Hamilton, Mannington; E. M. Hamilton, Belington; H. C. Harpfer, Wheeling.

Thomas L. Harris, Parkersburg; E. C. Hartman, Parkersburg; Gerald Eugene Hartle, Wardensville; D. G. Hassig, Charleston; H. H. Haynes, Clarksburg; James C. Hazlett, Wheeling; John P. Helmick, Fairmont; E. F. Heiskell, Morgantown; Charles D. Hershey, Wheeling; H. D. Hively, Ward; L. I. Hoke, Nitro; Charles A. Hoffman, Huntington; W. E. Hoffman, Charleston; George P. Heffner, Charleston; C. J. Holley, Wheeling; Frank J. Holroyd, Princeton; L. G. Houser, Beckley; Harold H. Howell, Madison; J. O. Howells, Bridgeport; J. Ross Hunter, Charleston.

H. D. Ireland, Hopemont; G. G. Irwin, Charleston; George D. Jeffers, Parkersburg; Carl E. Johnson, Morgantown; H. R. Johnson, Fairmont; A. L. Jones, Wheeling; E. Lloyd Jones, Wheeling; Wilda S. Joseph, Wheeling; N. K. Joseph, Wheeling; William John Judy, Parkersburg; William K. Kalbfleisch, Wheeling; Charles H. Keesor, Wheeling; John C. Kerr, Clarksburg; H. V. King, Morgantown; Jules I. Klein, Morgantown; T. M. Klug, Wheeling; Elizabeth Y. Kuffner, Point Pleasant.

J. J. Lawless, Morgantown; Lt. Col. L. Rush Lambert, M.C., Charleston; Verne L. Lance, Charleston; Frank V. Langfitt, Clarksburg; J. F. Lembright, Clarksburg; David B. Lepper, Bluefield; Arthur C. Litton, Charleston; R. W. Love, Moorefield; L. A. Lyon, Wheeling; D. A. MacGregor, Wheeling; U. G. McClure, Charleston; W. T. McClure, Wheeling; J. R. McCollum, St. Marys; Arley V. McCoy, Wheeling; C. G. McCoy, Wheeling; J. A. McCurdy, Wheeling; W. C. McCuskey, Wheeling; S. Elizabeth McFetridge, Martinsburg; Ralph McGraw, Follansbee; C. Scott McKinley, Charleston; J. P. McMullen, Wellsburg.

E. W. Mahan, West Alexander, Pa.; F. L. Matson, Wellsburg; F. O. Marple, Huntington; Joseph S. Maxwell, Fairmont; Burke Megahan, Elm Grove; John S. Meier, Wheeling; Guy H. Michael, Parsons; G. R. Miller, Fairview; Roy Ben Miller, Parkersburg; T. H. Millman, Earling; L. H. Mills, Clarksburg; Dana T. Moore, Parkersburg; Phoebia G. Moore, Mannington; G. V. Morgan, Fairmont; Hu C. Myers, Philippi.

L. E. Neal, Clarksburg; R. C. Newman, Spencer; J. W. Niedermyer, Charleston; Albert E. Nolte, Wheeling; Chester R. Ogden, Clarksburg; W. L. Oliver, Point Pleasant; Ray C. Otte, Wellsburg; J. E. Page, Clarksburg; Joseph Palmer, Wellsburg; J. L. Patterson, Holden; J. C. Peck, Moundsville; Edward N. Pell, Wheeling; C. W. Petty, Hartford; E. M. Phillips, Wheeling; Earl S. Phillips, Wheeling; Wilson S. Phillips, Wheeling; Howard T. Phillips, Wheeling; Robert W. W. Phillips, Wheeling; R. O. Pletcher, Lost Creek; C. G. Power, Martinsburg; A. Poole, West Union; Cecil O. Post, Clarksburg; Walter G. J. Putschar, Charleston.

W. A. Quimby, Wheeling; C. M. Ramage, Fairmont; Comdr. J. O. Rankin (MC) USNR, Memphis, Tenn. (Wheeling); Robert J. Reed, Wheeling; Robert J. Reed, Jr., Wheeling; T. G. Reed, Charleston; A. B. Rinehart, Weirton; R. O. Rogers, Bluefield; L. O. Rose, Parkersburg; C. C. Romine, Morgantown; Howard R. Sauder, Wheeling; L. O. Schwartz, Weirton; David Salkin, Hopemont; W. P. Sammons, Wheeling; Capt. William M. Sheppe (MC) USNR, U. S. Naval Hosp., Jacksonville, Fla. (Wheeling).

C. N. Slater, Clarksburg; Thomas A. Slate, Hollidays Cove; R. M. Sloan, Huntington; Charles E. Smith, Terra Alta; Robert J. Snider, Wheeling; E. W. Squire, Charleston; O. M. Staats, Wheeling; L. Phelps Stanley, Charleston; R. C. Starcher, Ripley; Harry G. Steele, Bluefield; Comdr. James K. Stewart (MC), USNR, Wheeling; William C. Stewart, Charleston; Joseph A. Striebich, Moundsville; F. P. Sutherland, Martins Ferry, O.; Walter C. Swann, Huntington; Kyle Y. Swisher, Fairview.

R. B. Talbott, Martinsburg; John O. Theis, New Martinsville; Harry V. Thomas, Clarksburg; C. Truman Thompson, Morgantown; James Thompson, Morgantown; J. L. Thompson, Weirton; Elliott L. Thrasher, Sistersville; J. M. Trach, Fairmont; George Holton Traugh, Fairmont; Robert E. Traul, Logan; S. W. Tretheway, Wheeling; E. A. Trinkle, Weston; J. R. Tuckwiller, Fairmont; Eldon B. Tucker, Morgantown.

Edward J. Van Liere, Morgantown; Edwin O. Vaughan, St. Albans; H. H. Veon, Parkersburg; Thomas U. Vermillion, Beckley; Walter E. Vest, Huntington; M. A. Viggiano, New Martinsville; James L. Wade, Parkersburg; Albert Wanner, Wheeling; W. Merle Warman, Morgantown; W. S. Webb, Wheeling; William A. Welton, Fairmont; S. Werthammer, Huntington; J. Frank Williams, Jr., Clarksburg; E. D. Wise, Fairmont; S. D. H. Wise, Parkersburg; Archer A. Wilson, Charleston; M. B. Williams, Wheeling; J. E. Wilson, Clarksburg; R. S. White, West Union; Charles Wingerter, Wheeling; R. J. Wilkinson, Huntington; Andrew Wilson, Wheeling; Chauncey Wright, Huntington; R. M. Wylie, Huntington; H. B. Young, St. Marys; Matthew F. C. Zubak, Wheeling.

Visiting Doctors

Major Samuel S. Altshuler, MC, Fletcher General Hospital, Cambridge, Ohio; Walter C. Alvarez, Rochester, Minn.; Richard B. Cattell, Boston, Mass.; Paul H. Cope,

Mt. Pleasant, Ohio; S. A. Cosgrove, Jersey City, N. J.; Charles A. Doan, Columbus, Ohio; David S. Greenberg, Steubenville, Ohio; Maj. Frank C. Hamm, MC, Fletcher General Hospital. Cambridge, Ohio.

Harry Harris, Martins Ferry, Ohio; Lt. Col. William S. Keller, M.C., USPHS, Chicago, Ill.; Major Ralph H. Kunstadter, MC, Ashford General Hospital, White Sulphur Springs, W. Va.; Major Abel Jay Leader, M.C., Ashford General Hosp., White Sulphur Springs, W. Va.; John S. Liggett, St. Clairsville, O.

Lewis L. Liggett, St. Clairsville, O.; E. W. Mahan, West Alexander, Pa.; Geo. C. Malloy, Zanesville, Ohio; Paul G. Modie, Barnesville, O.; Lt. Col. O. E. Nadeau, MC, Fletcher General Hospital, Cambridge, O.; Lt. Col. John W. R. Norton, MC, Office of the Surgeon General, Washington, D. C.; Maj. Lewis S. Pecher, MC, Fletcher General Hospital; Maj. Arthur E. Rappaport, MC, Fletcher General Hospital; Peter Cyrus Rizzo, MC, Fletcher General Hospital; A. E. Thompson, Washington, Pa.; J. I. Thompson, Smithfield, O.; Wm. W. Waddell, Jr., Charlottesville, Va.; H. S. West, St. Clairsville, O.; Albert E. Weinstein, Steubenville, O.

Other Visitors

J. R. Ardit, Cincinnati; L. E. Boehme, Cincinnati; H. G. Brannen, Pittsburgh; Dorothy Brobander, Wheeling; Baker L. G. Bryant, Cincinnati; E. A. Christiansen, Pittsburgh; Paul N. Clayton, Detroit; Arthur H. Cox, Pittsburgh; Gladys M. Craig, Charleston; D. F. Curtis, Wheeling; E. L. Earle, Wheeling; Dennison Ellis, Huntington; Laurene C. Fisher, Charleston; Tom Fulton, Charleston; Wendell E. Funkhouser, Wardensville; Steve Furches, Charleston; F. C. Garvin, Pittsburgh; A. B. Ginden, Charleston; J. R. Graham, Wheeling; C. R. Guffey, Philadelphia; Paul D. Halley, Charleston; J. W. Harper, Uniontown; Ralph E. Hansen, New York; J. E. Hart, Wheeling; C. L. Heaberlin, Charleston; E. R. Hollar, Duquesne, Pa.; Frank E. Hostetler, Wheeling; Geo. J. Hulcher, Richmond; C. W. Hunter, Pittsburgh; Thomas G. Hull, Chicago.

D. W. Iams, Pittsburgh; Annette King, Charleston; Cam King, Pittsburgh; J. T. Latham, Wheeling; H. R. Lemley, Clarksburg; Joan McCollum, RN, St. Clairsville, O.; Ralph McDaniels, Philippi; H. W. McDaure, New York; F. D. McGann, Wheeling; C. N. Melhinch, Philadelphia; Alberta M. Morgan, Charleston.

Mrs. O. E. Nadeau, Cambridge, O.; J. O. Pearson, Wheeling; Eason G. Pritchard, Bluefield; C. A. Rouse, Newark; W. H. Rumbel, Youngstown; R. C. Schwarz, Wheeling; Sister Mary Joseph, Wheeling; Sister Mary Ruth, Wheeling; Sister Mary Gratia, Wheeling; F. DeStefano, Pittsburgh; H. A. Spencer, Wheeling; Charles Stevens, Detroit; Thomas W. Storer, Pittsburgh; W. L. Supler, Pittsburgh; J. A. Vassar, New York; Fred S. Watson, St. Louis; R. J. Wilkinson, Jr., Huntington; D. C. Yohe, Pittsburgh; W. R. Yohe, Glen Campbell, Pa.; E. W. Zeller, Philadelphia.

COUNCIL MEETS AT WHEELING

At the pre-convention meeting of the Council, held at the Windsor Hotel, Wheeling, Sunday, May 14, 1944, there was a full attendance of the members and elective officers of the Association.

Dr. R. H. Edwards, of Welch, was elected a member of the Publication Committee to succeed Dr. J. C. Hutchinson, who resigned to accept an appointment on the surgical staff at the Mayo Clinic. Captain W. M. Sheppe (MC), USNR, of Wheeling, who is now stationed at the U. S. Naval Hospital, Jacksonville, Florida, was reelected a member of the committee for the five year term ending December 31, 1949.

Honorary Members

The following doctors were elected honorary life members of the State Medical Association: Richard Hardwick, Huntington; Richard J. Brown and Edwin A. Davis, Charleston; Samuel Hewes Phillips, St. Albans; Harry Hood Esker, Clarksburg; Robert Martin Akers, Kermit; and George W. Johnson, McAlpin.

The Council unanimously nominated Dr. I. Clay Hicks, of Huntington, now an honorary member of this Association, for Affiliate Fellowship in the American Medical Association.

Special Committee

The chairman was directed to appoint a special committee to consider the possible sale of residence property owned by the Association, located in the South Ruffner section of Charleston, and, further, to consider the matter of the surrender of an insurance policy owned by the Association, such committee to be given full power to act.

The Chairman appointed the following as members of the committee: Dr. Walter E. Vest, Chairman, Huntington; and, Drs. Frank V. Langfitt, Clarksburg; Robert J. Reed, Jr., Wheeling; Thomas L. Harris, Parkersburg; and, W. A. McMillan, Charleston.

Report of Fact Finding Committee

Dr. Ray M. Bobbitt, Chairman of the Fact Finding and Planning Committee, submitted the following report, which after discussion, was accepted and the recommendations unanimously approved:

"The committee reaffirmed the action that was taken by the Central State Committee in a meeting at Charleston in the Spring of 1944, in agreeing with representatives of West Virginia Hospitals and Hospital Service Plans in trying to obtain the reenactment, with minor amendments, of the bill affecting medical-surgical-hospital plans in the regular session of the legislaature in 1943. The committee suggests that the entire matter be left in the hands of the Legislative Committee for such action as may be necessary, after consultation with attorneys.

"It is suggested that the Central State Committee, composed of Drs. R. M. Bobbitt, Huntington, Chairman, D. A. MacGregor, Wheeling, and R. O. Rogers, Bluefield, be directed to keep in close touch with the hospital groups and endeavor to obtain a uniform contract and uniform rules and regulations. It is further suggested that the committee endeavor to have each local medical-surgical-

hospital group change the name of its organization so as to include either at the beginning or end thereof the words. 'West Virginia.' so as to show that it is the 'West Virginia hospital. or medical or surgical plan' of the particular component society in the area where located.

"The committee suggests that the policy be pursued of permitting and urging component societies to handle all complaints concerning the practice of osteopaths in their various communities.

"It is recommended that at the end of the war the transfer of certain government equipment. appliances and drugs. to civilian emergency medical service organizations be authorized subject to the approval of the government. such equipment to be used for emergency medical relief in the event of disaster.

"The committee hereby refers to the Council for such action as may be deemed necessary, the matter of a change in Workmen's Compensation fees."

Workmen's Compensation Fees

The chairman was directed to appoint a special committee to investigate the matter of Workmen's Compensation fees, such committee to include one member representing each of the following fields: (1) E. E. N. T.; (2) General Surgery; (3) Urology; (4) Internal Medicine; (5) Neurology, and (6) two members representing Orthopedic Surgery.

Subsequently, the Chairman appointed the following as members of this committee: Dr. E. A. Trinkle, Chairman, Weston; and, Drs. Harry V. Thomas, Clarksburg; J. L. Hutchison and E. F. Reaser, Huntington; and, Randolph L. Anderson, Thomas G. Reed and W. C. Stewart, Charleston.

Revision of By-Laws

Dr. J. Howard Anderson, chairman of the special Committee on the Revision of the Constitution and By-Laws, submitted a report suggesting several amendments. The report was discussed item by item, and was approved unanimously, with the understanding that the amendments would be offered by the chairman at the first meeting of the House of Delegates on the following day.

Special Assessments for 1945

After full discussion of Association finances, the chairman was instructed by the unanimous vote of the Council to recommend the levying of an assessment of $5 against each member of the Association for the year 1945.

The report of the treasurer, Dr. T. M. Barber, which included a copy of the audit of the finances of the Association made by a certified public accountant in January, 1944, heretofore printed in the JOURNAL, was ordered received and filed. The Executive Secretary, Mr. Charles Lively, submitted a statistical report concerning the activities of the Association during the past year, and stated that his annual report as secretary would be presented to the House of Delegates at the first session, May 15.

The matter of a change in Department of Public Assistance medical fees was referred to the D. P. A. Advisory Committee for such action as may be deemed necessary.

The meeting was attended by the following officers and councillors: Dr. R. J. Wilkinson, Chairman, Huntington; Dr. R. J. Reed, Jr., President, Wheeling; Dr. T. M. Barber, Treasurer, Charleston; Drs. R. O. Rogers, Bluefield; J. B. Clinton, Fairmont; R. D. Gill, Wheeling; Guy H. Michael, Parsons; Carl E. Johnson, Morgantown; C. O. Post, Clarksburg; E. A. Trinkle, Weston; James L. Wade, Parkersburg; Walter C. Swann, Huntington; Frank J. Holroyd, Princeton; N. H. Dyer, Bartley; Andrew E. Amick, Charleston, and W. P. Bittinger, Summerlee; and, Mr. Charles Lively, secretary *ex officio*.

Others present were: Drs. H. G. Steele, first vice president, Bluefield; Thomas G. Reed, second vice president, Charleston; Walter E. Vest, Chairman of the Publication Committee, Huntington; Ray M. Bobbitt, Chairman of the Fact Finding and Planning Committee, Huntington; and J. Howard Anderson, Hemphill, Chairman of the Special Committee on the Revision of the Constitution and By-Laws.

DR. JAMES A. RYAN SMA PRESIDENT

Due to the sudden death of Dr. William T. Wooton, president of the Southern Medical Association, the vice president, Dr. James A. Ryan, of Covington, Kentucky, succeeds to the presidency. Doctor Ryan was general chairman of the committee on arrangements at the Cincinnati meeting in November, 1942. Under the constitution and by-laws of the SMA, in the event of the death of the president, the vice president succeeds to that office. Accordingly, Doctor Ryan is now president, his term expiring with the St. Louis meeting in Nov.

AMERICAN BOARD OF OBS. AND GYN.

The general oral and pathology examinations (Part II) for all candidates will be conducted by the American Board of Obstetrics and Gynecology, Inc., at the William Penn Hotel, Pittsburgh, June 7-13, 1944. Applications for the 1945 examinations are now being received by Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh 6, Pa.

DR. ROBT. J. REED, JR., OFFERS PLAN FOR COUNTY MEDICAL SERVICE CENTERS

The sessions of the 77th annual meeting of the State Medical Association, held at Wheeling, May 15-16, ended at a Victory Dinner at the Wheeling Country Club on the evening of the second day. The doctor registration totaled 269, with many distinguished guests present from the Army, Navy, U. S. Public Health Service and nearby Army general hospitals.

Scientific Sessions

The ballroom at the Windsor Hotel was crowded at all scientific sessions and the technical and scientific exhibits were visited by most all of the doctors who attended the meeting. The scientific sessions were unusually interesting, and the program committee, composed of Drs. R. D. Gill, Chairman, Thomas L. Harris, and J. P. McMullen, succeeded in arranging a program sufficiently varied to interest doctors in general and limited practice.

Scientific Exhibits

Not within recent years has such an interesting scientific exhibit been arranged. Dr. Hu Myers of Philippi, as chairman of the committee which included Drs. John P. Helmick of Fairmont and Fred Whittlesey, of Morgantown, succeeded in obtaining the cooperation of doctors, hospitals, the State Health Department, the American Medical Association, and others, in arranging modern exhibits of particular interest to the medical profession.

Technical Exhibits

The technical exhibits overflowed the clubroom and mezzanine into the lobby. These were very interesting, notwithstanding the fact that three special booths were lost in transit and two so badly damaged that substitutes had to be arranged.

President's Address

The annual address of the president was delivered before a packed house on Monday evening, May 15. Dr. Reed's main theme in his address which was titled, "Beyond the Blue Horizon," was adequate medical care for all the people without regard to economic status.

In his address, [Ed: The President's address will appear in full in the July issue of THE JOURNAL], Dr. Reed predicted that there will always be in this country the private practice of medicine for those who desire it and are willing to pay for it. "Let us assume," he said, "that there are great hordes of people in this country who want adequate and competent medical care and who would prefer the physician of their choice, but if this were not always possible, would accept an equally competent physician." Doctor Reed then went on to propose the establishment all over the country of county or area medical service centers under the control and guidance of local medical societies, rendering complete medical service for all persons at the same annual rate, depending upon the size of the family, all of whom would be on an equal footing and, "would share and share alike in its benefits". The county, state and federal government would pay the same rate for indigents.

The successful operation of medical groups in West Virginia was cited by Doctor Reed as an example of what can be accomplished in this type of medical practice. He advocated the establishment of county or area groups in which all doctors would be expected to participate.

After expressing gratitude to the doctors in the military service and praising them for the sacrifices they have made and are making, he pledged to them the faithful assistance of the doctors at home in their efforts to become established or reestablished in their profession upon their return home after the war.

PLANNING COMMITTEE REPORTS

A special meeting of the Fact Finding and Planning Committee of the State Medical Association was held at the Windsor Hotel, Wheeling, May 14, 1944. The following members were present: Drs. Ray M. Bobbitt, Huntington, Chairman; D. A. MacGregor, Wheeling; Frank V. Langfitt, Clarksburg; Carl E. Johnson, Morgantown; R. O. Rogers, Bluefield; G. G. Irwin, Charleston; E. A. Trinkle, Weston; and Mr. Charles Lively, secretary *ex officio*. Drs. R. J. Reed, Jr., Wheeling; Andrew E. Amick, Charleston; R. J. Wilkinson, Huntington, and Walter E. Vest, Huntington, were also present.

The committee was in session for nearly three hours and unanimously approved recommendations to be made to the Council and the House of Delegates. These recommendations are embodied in two separate reports which are printed elsewhere in this issue of THE JOURNAL.

In addition to the matters acted upon and reported to the Council and the House of Delegates, the committee directed the Secretary to inform Dr.

Walter Donaldson, of Pittsburgh, chairman of the A. M. A. War Participation Committee, that this Association committee is ready and willing to cooperate in every way possible in the work of his committee, and will function as a War Participation Committee in this state. The secretary was directed to request Dr. Donaldson to refer to the committee all matters that should have consideration at the present time.

The various matters that were submitted to the Council and House of Delegates for consideration will be acted upon further by the committee at a meeting to be held early in the fall. It is understood that the committee will cooperate fully with the legislative committee in the matter of drafting a program to be presented to the legislature at the regular session in January, 1945.

The committee declined to take any action with reference to the suggestion that a bureau of public relations or office of information be established at Washington in addition to the bureau now being operated by the American Medical Association; and also declined to take any action concerning sex education in the junior and senior high schools of the state, as proposed by a representative of the state health department.

The matter of a change in Department of Public Assistance fees was left for action by the D. P. A. Advisory Committee.

NEW SECTION OFFICERS

The annual election of officers of special societies and sections within the Association, was held at luncheon meetings at Wheeling, May 15-16. Officers for the ensuing year were elected as follows:

Eye, Ear, Nose and Throat: Verne L. Lance, Charleston, chairman; R. E. Traul, Logan, secretary.

Internal Medicine: W. C. Stewart, Charleston, chairman; Howard R. Sauder, Wheeling, secretary.

Pediatrics: Andrew E. Amick, Charleston, chairman; A. A. Shawkey, Charleston, secretary.

Surgery: Guy H. Michael, Parsons, chairman; John S. Meier, Wheeling, secretary.

West Virginia Heart Association: Frank J. Holroyd, Princeton, president; C. O. Post, Clarksburg, vice president; John P. Helmick, Fairmont, secretary.

West Virginia Obstetrical and Gynecological Society: Gilbert A. Ratcliff, Huntington, president; Henry E. Baum, Charleston, vice president; H. G. Steele, Bluefield, secretary-treasurer.

The West Virginia Chapter of the American College of Physicians met cojointly with the West Virginia Heart Association. Dr. Howard R. Sauder, of Wheeling, was elected chairman of the West Virginia membership.

At the annual luncheon meeting of the Medical College of Virginia alumni, Dr. Dana T. Moore, Parkersburg, was elected president.

CAPT. JABBO HEADS MC REPAIR DEPOT

Captain John J. Jabbo, of Wheeling, is in command of a Medical Corps repair depot in England, the only one of its kind in the United States Army, according to a release from the E. T. O. headquarters, U. S. Army. Originally staffed by three men who serviced x-ray machines, the unit has grown and now repairs everything from hospital emergency generators and iceboxes to cardiographs and small sterilizers. Electro-medical equipment that will be used in healing combat casualties is now being installed, repaired and serviced. The detachment has installed or serviced x-ray machines in every American hospital in the United Kingdom.

Captain Jabbo formerly operated his own x-ray supply company at Wheeling. Another West Virginian, Corporal Ohather Walden, of Midkiff, is attached to the unit as a mechanic.

Until his enlistment in the Army, Captain Jabbo regularly attended the annual meetings of the State Medical Association as a representative of an x-ray company.

INFORMATION OFFICE AT WASHINGTON

The Council on Medical Service and Public Relations of the American Medical Association has established an information office in Washington under the direction of Dr. Joseph S. Lawrence, of Albany, New York, who has served as executive officer and legislative representative of the New York State Medical Society since 1924. He will serve as consultant and will be associated with Dr. G. Lombard Kelly, who has been named as permanent secretary, and who will divide his time between Washington and Chicago. The office, which was opened in April, is located in Suite 900, Columbia Medical Building, 1835 I St., NW, Washington, D. C.

MRS. SCOTT A. FORD INSTALLED AS PRESIDENT OF WOMAN'S AUXILIARY

Mrs. Scott A. Ford of Beckley, long active in Auxiliary work, was elevated to the presidency of the Woman's Auxiliary to the West Virginia State Medical Association at the 20th annual meeting at Wheeling, May 16. The meeting was presided over by Mrs. John P. Helmick, of Fairmont, retiring state president, and the new officers were installed by Mrs. Eben J. Carey, of Milwaukee, national auxiliary president. Besides Mrs. Ford, the following elective officers were installed for the ensuing year:

President elect, Mrs. Ulysses G. McClure, Charleston; first vice president, Mrs. H. M. Andrew, Weston; second vice president, Mrs. P. C. Spangler, Pageton; third vice president, Mrs. A. G. Lanham, Ronceverte; fourth vice president, Mrs. V. A. Deason, Logan; recording secretary, Mrs. Archbold M. Jones, Parkersburg; corresponding secretary, Mrs. L. E. Shrewsbury, Beckley; treasurer, Mrs. G. A. Ratcliffe, Huntington.

Mrs. Scott A. Ford, Auxiliary President

Mrs. Ford has announced the appointment of the following chairmen of standing committees: Archives, Mrs. Ross P. Daniel, Beckley; finance, Mrs. Dana T. Moore, Parkersburg; historian, Mrs. Carl Van Horn, Fairmont; Hygeia, Mrs. A. C. Echols, Layland; legislation, Mrs. Harold P. Evans, Keystone; organization, Mrs. Ulysses G. McClure, Charleston; parliamentarian, Mrs. Harry V. Thomas, Clarksburg; press and publicity, Mrs. Harry Beard, Huntington; program, Mrs. W. E. Hoffman, Charleston; public relations, Mrs. Herbert M. Beddow, Charleston; revisions, Mrs. Delmas E. Greeneltch, Wheeling.

The following chairmen of special committees have also been appointed by Mrs. Ford: Bulletin, Mrs. Ralph M. Fisher, Weston; speakers bureau, Mrs. V. Eugene Holcombe, Charleston; war participation, Mrs. C. T. Clark, Iaeger; Southern Medical, Mrs. Welch England, Staunton, Va.; special projects, Mrs. Ralph Hogshead, Montgomery.

The meeting of the auxiliary was one of the best in the history of the organization. Registration totaled 106, and all of the meetings were well attended.

Captain W. M. Sheppe (MC), USNR, who is assigned to the U. S. Naval Hospital at Jacksonville, Florida, was the guest speaker at the luncheon Monday, May 15, at the Wheeling Country Club. His subject was "Recent Advances in Medical Care of Naval Personnel." Honor guests included Mrs. Eben J. Carey, National Auxiliary President; Dr. Robert J. Reed, Jr., President of the State Medical Association, and Drs. Hu C. Myers, H. V. Thomas, and R. B. Bailey, members of the advisory board.

At the meeting on Tuesday, May 16, Mrs. Eben J. Carey spoke on the three objectives of the year's work, the health program, recruiting of cadet nurses, and medical legislation. She was followed by Mr. Charles Lively, secretary of the State Medical Association, who spoke on medical legislation.

The formal election of new officers followed the report of the nominating committee, of which Mrs. Ralph Hogshead is chairman. The report was formally presented by Mrs. Ross P. Daniel.

The members of the auxiliary were guests of the Wheeling Clinic on Tuesday night at a reception at the Country Club, and at the Victory Dinner which followed. One of the highlights of the meeting was the luncheon at the historic Washington Farms, at which Mrs. E. M. Phillips was hostess. The past presidents were entertained at a breakfast on Monday morning at Hawthorne Court, where Mrs. Howard T. Phillips was hostess.

RECIPROCITY WITH KENTUCKY

Approval of a new reciprocity agreement with Kentucky for the licensing of physicians has been announced by the Public Health Council. The agreement was reached during the three-day meeting of the council in Charleston early in May, which was attended by Dr. P. E. Blackerby, state health commissioner of Kentucky. Reciprocal relations have been maintained for the past several months under a "gentlemen's agreement" between the health departments of the two states.

The following doctors were licensed by reciprocity during the meeting: Ray Edward Burger, Welch; Frank Joseph Burian, Williamson; Ralph Sherman Buvinger, Point Marion, Pa.; Mary Virginia Gallagher, Charleston; Milton Judson Lilly, Jr., Huntington; Samuel Louis Shriber, Charleston; Ralph Edgar Siegel, Welch; Marguerite Georgene Stemmermann, Beckley; and, Joseph Eldred Seebert, Oak Hill.

The appointment of Dr. Walter J. Riley, formerly of Sutton, as health officer in District No. 4, at Weston, was confirmed together with the appointment of Dr. C. A. Thomas, of Weston, as health officer in District No. 5, with headquarters at Romney.

The council announced the revocation of the license of Dr. Warren Burton Taylor, of Logan county, who was convicted of second degree murder in the death of Lee Porter, 38-year-old miner, of Ethel. Dr. Taylor is serving a term of from 5 to 18 years in the state penitentiary at Moundsville.

ANNUAL SESSION OF THE A. M. A.

The 94th annual session of the American Medical Association will be held at the Palmer House, Chicago, June 12-16. The House of Delegates will convene June 12, at 10, A. M., and the opening general meeting is scheduled for the following evening. Sections will meet on June 14, 15 and 16.

Registration booths will open Monday morning, June 12, at the Hotel Stevens. Scientific exhibits will be set up at the Palmer House and technical exhibits at the Hotel Stevens.

Drs. Walter E. Vest, of Huntington and Ivan Fawcett, of Wheeling, are the A. M. A. delegates from West Virginia, and Drs. W. P. Black, of Charleston, and James L. Wade, of Parkersburg, are alternates.

DR. HORSLEY TO BE HONORED

Dr. Shelton Horsley, surgeon in charge at St. Elizabeth's Hospital, Richmond, who has a wide acquaintance among members of the medical profession in West Virginia, will be awarded the honorary degree of Doctor of Science at the September commencement exercises of the Medical College of Virginia.

Doctor Horsley has been one of the leaders in the south in the encouragement of research on the part of others. He is nationally known for his own research in arterial circulation reversal, suturing arteries, and surgery of the stomach and arteries.

For his work on arterial circulation reversal, he was awarded a gold medal by the Southern Medical Association. He has also been awarded several certificates of honor by the American Medical Association. He is now serving as the surgeon member of the National Advisory Cancer Council. He has been president of the Virginia Academy of Science, the Richmond Academy of Medicine, the Medical Society of Virginia, and the Southern Medical Association.

DEPUTY STATE HEALTH COMMISSIONER

Dr. A. L. Chapman, of New Jersey, who has been on duty in the office of Dr. W. K. Sharpe, of the USPHS, Bethesda, Maryland, has been assigned to the state health department at Charleston where he will serve as deputy state health commissioner, pending the selection of a doctor for this office under the Merit System.

The appointment of a deputy commissioner has been approved by the Public Health Council of West Virginia, and certain administrative duties will be assigned to him by Doctor Offner when he assumes his new duties June 15. The deputy will be in full charge of the office during the absence of the state health commissioner, who is frequently called upon to attend public health conferences.

SUPERINTENDENT AT WELCH EMERGENCY

Dr. Irvine Saunders, of Welch, has been named by Governor M. M. Neely as superintendent of the Welch Emergency Hospital. He succeeds Dr. F. E. LaPrade, who retired several months ago because of ill health. Dr. J. C. Hutchinson, who has been serving as acting superintendent, is now on the surgical staff at Mayo Clinic. Dr. Saunders, who has been on the staff of Grace Hospital at Welch since 1942, is secretary of the McDowell County Medical Society.

COMMANDER LAPHAM ON ACTIVE DUTY

Commander Max E. Lapham (MC), USNR, formerly Executive Officer of the Procurement and Assignment Service at Washington, has been ordered to active duty at the Naval Hospital at San Diego, Cal. Dr. Paul C. Barton, who has been serving in an acting capacity during Commander Lapham's recent serious illness, has been appointed Executive Officer by the Directing Board.

NEW MEMBER OF STAFF

Dr. Arthur A. Rodriguez, assistant surgeon in the USPHS, recently stationed at Chicago, has been named as a member of his staff by Dr. R. D. Wright, director of the Kanawha Valley Medical Center, the new institution for the treatment of venereal diseases, at South Charleston.

Doctor Wright reports that over 300 patients have been admitted to the center since its opening on March 6, 1944.

CHARLESTON DOCTORS HONORED

Dr. Archer A. Wilson and Dr. Oscar Noel Morrison, of Charleston, have been cited by the War Department for faithful and meritorious service as civilian medical examiners at the armed forces induction station at Huntington. Each has been presented with the War Department emblem for civilian service, as authorized by regulations dated October 5, 1943, which states in part:

"It is the policy of the War Department to recognize the contribution being made by its civilian employees to the successful prosecution of the war, and to encourage a greater awareness of their active personal participation in the achieving of ultimate victory by presenting emblems to civilian employees in the departmental and field service who have rendered faithful and meritorious service."

RELOCATIONS

Dr. H. M. Jackson, who has been in industrial practice at Fayetteville since 1942, has moved to Brooklyn, West Virginia.

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Dr. John M. Foley, former radiologist at the Wheeling Hospital, is now located at Detroit, having moved there from Peoria, Illinois, early in May.

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Dr. R. J. Ford, formerly on the staff at the Weston State Hospital, is now a member of the staff at Spencer State Hospital, at Spencer.

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Dr. Eugene O. Wright, who has been serving as medical director for Simpson Creek Collieries, at Galloway, has located at Fairmont.

TUBERCULOSIS ABSTRACTS

(Continued from page 187)

a severe local reaction with, at the same time, pain in the chest and dyspnea. Radiological examination a few days later showed the presence of a small pleural effusion on the right side together with a fresh area of exudative disease in the mid and lower zones.

Case 4.—Female, aged 19. This girl was working in an emergency hospital as a V.A.D. and was vaccinated along with her colleagues in July, 1942. She had a severe local reaction and was in bed for four days. Subsequently she felt tired, and three weeks later had the misfortune to fall victim to a mild epidemic of glandular fever which attacked some of the hospital staff. She recovered rapidly from the fever but the lassitude previously present persisted, and shortly after she had a sudden hemoptysis. Radiological examination showed scattered infiltration throughout the left upper and mid zones, with commencing cavitation immediately below the clavicle.

Discussion and Summary

In view of the relatively few references to the association between vaccination and pulmonary tuberculosis which we have been able to find it is felt that these cases should be recorded. It is impossible to draw any definite conclusions from isolated instances such as these, but it would appear that there is sufficient evidence here to justify the assumption that vaccination may cause a flare-up in a latent focus.

Our results are at variance with those reported by Stone, but it should be remembered that his cases were under sanatorium conditions at the time of vaccination, while those we have recorded were engaged in their normal occupations, and therefore no more precautions were taken in their cases than would be taken with the average healthy individual.

The necessity for widespread vaccination of the population will not, we hope, arise again, but should it so happen it would be well to exercise special caution before submitting to vaccination known cases of pulmonary tuberculosis.

Smallpox Vaccination and Pulmonary Tuberculosis, R. Y. Keers, M. D. and P. Steen, M. D., British Journal of Tuberculosis and Diseases of the Chest, July-October, 1943.

WITH DOCTORS IN THE SERVICE

Lieut. (jg) Heyes Peterson (MC), USNR, of Wheeling, who has been located at the U. S. Naval Convalescent Hospital at Harriman, New York, has been assigned to sea duty.

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Comdr. Vincent T. Churchman, Jr. (MC), USNR, of Charleston, who has been stationed at Lake Forest, Illinois, for several months, is now serving with our armed forces overseas.

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Dr. Frederick C. Reel, of Charleston, who has been assigned to the Woodrow Wilson General Hospital at Staunton, Virginia, has been promoted to the rank of Captain and transferred to the Valley Forge General Hospital at Phoenixville, Pa., and placed in charge of the EENT section.

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Captain William M. Sheppe, of Wheeling, who has been stationed at the U. S. Naval Hospital at Quantico, Virginia, since 1942, has been transferred to the U. S. Naval Hospital at Jacksonville, Florida, where he reported for duty May 24. He attended the annual meeting at Wheeling and delivered the principal address at the annual luncheon of the Woman's Auxiliary. He also served as toastmaster at the Victory Dinner at the Wheeling Country Club.

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Captain James E. Wilson, Jr., of Clarksburg, has been transferred from Vancouver Barracks, Washington, to the Toumey General Hospital at Palm Springs, Cal.

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Comdr. H. G. Little, of Wheeling, who has been assigned to the U. S. Naval Hospital at Quantico, Virginia, for several months, is now on sea duty somewhere in the South Pacific.

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Captain Julian Kaufman, of Charleston, is serving as chief of cardiology at Stark General Hospital, Charleston, S. C., having been transferred from Camp Rucker, Alabama. His work consists in caring for cardiac cases invalided home from overseas until they recover sufficiently to be sent to the station hospital located nearest their homes. Lieutenant William C. Boggs, of Wheeling, is serving as chief of dermatology at the same hospital.

Major Michael G. Hresan, of Minden, has been transferred from the 85th CA Medical Detachment at Newport News to the 113th Infantry at Camp Pickett, Va.

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Lt. Col. Bert Bradford, Jr., of Charleston, writes from England that he recently visited with two West Virginia doctors stationed in his area, Captain C. B. Buffington, of Wheeling, who has been overseas for 18 months, and Captain G. L. Todd, of Princeton, who is attached to the staff of a nearby general hospital. He reports that Major T. R. Boling, of Grantsville, who has been in the Southwest Pacific for two years, is serving as deputy base surgeon somewhere in New Guinea.

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West Virginia Doctors in India—Left to Right, Captain John W. Hash, Charleston; Lieut. Charles Robinson, New York City; Major Arthur C. Chandler, Charleston; and, native boy.

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Captain Clinton B. Chandler, of Iaeger, who has been stationed at Camp Rucker, Alabama, is now assigned to the 132nd Station Hospital at Camp Santa Anita, Arcadia, Cal.

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Lt. Comdr. John Lutz (MC), USNR, formerly attached to the Naval Recruiting Station at Charleston, was back home recently for a short visit. He has been stationed for over a year on a tanker operating in the Southwest Pacific. He has visited the Marshall Islands and other islands where the Navy has played such a prominent part in that theater of operations. As ship's doctor, he takes

care of the medical and surgical work and says that there is not much of either. He has treated Japanese prisoners on several occasions.

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Captain T. P. Mantz, of Charleston, who was formerly stationed at Camp Bowie, Texas, writes from England as follows:

"This is just a note to let you know where I am and to extend thanks for THE JOURNAL which you so kindly send to us in the service. It arrives regularly and I get a great deal of satisfaction reading it, particularly the page, 'With Doctors in the Service.' It enables me to keep informed as to the activities and whereabouts of my fellow Society members in the armed forces.

"Great credit is due Dr. A. A. Wilson and Dr. W. G. J. Putschar for their very excellent papers published in the last issue (Ed.: Issue for April, 1944).

"Col. Bert Bradford, of Charleston, has visited me twice in the past thirty days. He seems to be quite busy now.

"This being the eve of the invasion, I can tell you but little of myself or surroundings. Enclosed is a picture showing our chief method of transportation here in England."

Capt. T. P. Mantz, Somewhere in England

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Captain James H. Walker, MC, of Charleston, is with the Army Air Corps somewhere in Italy. He writes that the life there is not bad. "We have one electric light per hut, fairly good meals, and enough to keep us busy. * * * The medical work consists of sick call, first aid to casualties returning from missions, and preventive psychiatry, or keeping the flying personnel in the proper frame of mind to finish their tour of combat duty."

Captain J. T. Peters, of South Charleston, who was formerly stationed at Fort Thomas, Kentucky, is now serving with a station hospital somewhere in India.

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Lieut. John R. Godby (MC), USNR, who has served with the Marines for two years in the Southwest Pacific, returned to Charleston recently, where he is on temporary duty at the Naval Recruiting Station. Early in 1943, he was awarded the Silver Star Medal for "conspicuous gallantry and intrepidity in action against the enemy" on Guadalcanal, in November, 1942.

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Captain Ralph C. Greenberg, of Masontown, has been on detached service in the British Isles. He is now assigned to the diagnostic ward of a station hospital and also serves as pathologist and chemical warfare officer.

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Captain Leonard M. Eckmann, of South Charleston, who is with a combat outfit in England, writes that his set up is one of the most comfortable he has had since he has been in the Army. The dispensary is in an old Nissen hut. "We are in an agricultural area," he writes, "surrounded by narrow, winding roads, high hedges, big green fields, and lots of cows and sheep, plus military installations that cannot be described." He continues:

"Most of my exercise is gotten on an English bicycle with a very hard seat. It is the custom here to pedal around, and I find it quite a nice way to make rounds, except when the wind is blowing hard.

"There is not too much for amusement here. We get into London now and then for 24 hours, but I've been there only once. I haven't met any West Virginians as yet; however, in a theatre in London I met a college classmate I saw last in 1933, and in a station hospital I met an officer who used to be in the same armored division with me.

"I am enclosing a sample of foil that is thrown out from airplanes to 'confuse the radar'."

NO MORE APO ADDRESSES

At the request of the Post Office Department, we have discontinued publishing information concerning APO and FPO addresses of members in the service.

While letters addressed merely to an APO or FPO number are forwarded to addresses after processing through available postal directories, the service is anything but satisfactory on account of unavoidable delay in delivery. In addition, it adds much to the burdens of an already overworked Army and Navy Postal Service.

In all cases where the information is in our files, we shall be glad to furnish by letter complete addresses of the members of the Association now serving with the armed forces.

Obituaries

HARRY H. BOLTON, M. D.

Dr. Harry H. Bolton, 57, formerly of Thomas, died April 22, 1944, at Hilliard, Florida, following a long illness. He had retired last year and moved with his family to that city.

Doctor Bolton graduateo from Emory University in 1914 and located in West Virginia after his discharge from the medical corps of the Army at the end of World War I. He practiced continuously as medical director for Davis Coal and Coke Company, at Pierce and Thomas, West Virginia, from 1920 to 1943. He was a member of the Barbour-Randolph-Tucker Medical Society and the State and American Medical Associations. He is survived by his wife, Lula Bolton, one daughter, Kathryn L. Bolton, and six sisters and four brothers.

WILLIAM TURNOR WOOTTON, M. D.

Dr. William Turnor Wootton, Hot Springs National Park, Arkansas, the incumbent president of the Southern Medical Association died at St. Luke's Hospital, St. Louis, of an embolism on Tuesday evening, May 2.

Doctor Wootton was born April 12, 1878, at Poolesville, Maryland. He was the son of Doctor Edward and Betty (O'Rear) Wootton. His premedical education was received at Maryland Agricultural College and he received the degree of Doctor of Medicine at the University of Maryland in 1899. He was married October 5, 1904, to Emmaline Whittington. For many years he had been engaged in the practice of internal medicine at Hot Springs, with special emphasis upon arthritis. He was captain and assistant surgeon in the U. S. Volunteers in the Spanish-American War, and served in the Philippines in 1900-1902. During World War I he held the commission of major in the medical reserve corps, but was not called to active duty.

Doctor Wootton had been a member of the Council of the Southern Medical Association, and at the Richmond meeting in 1942 was chosen president-elect. He was installed as president at the meeting in Cincinnati last November. He was in St. Louis for a meeting of the Council of the Southern Medical Association and while there was suddenly stricken ill and died within a few hours.

MARION HENDERSON POWERS, M. D.

Dr. Marion H. Powers, 62, of Weirton, died May 4, 1944, at McCaza, Quebec, Canada, while on a vacation at the Sakaigan Hunting and Fishing Lodge. Death was due to coronary occlusion.

Doctor Powers was born in Belmont County, Ohio, son of Robert J. and Henrietta Keyser Powers. He received his early education at Moundsville and graduated from Jefferson Medical College in 1907. He interned at Metropolitan Hospital, New York City, and then engaged in general practice at Point Marion, Pa., for several years, after which he took postgraduate work at Philadelphia Polyclinic Hospital and the Wills Eye Hospital, Philadelphia.

He served in the medical corps during World War I and went overseas with Base Hospital 14, being discharged at the end of the war with the rank of captain. He located at Weirton in July, 1919, where he practiced until his death. He was a member of his local medical society and the State and American Medical Associations. He was a member of the staff of the Ohio Valley and Gill Memorial Hospitals.

PAUL DOUGLAS HAYMAN, M. D.

Dr. Paul Douglas Hayman, 37, of Huntington, died May 1, 1944, after several months' illness of glioma.

Doctor Hayman was born at Mercer's Bottom, in Mason County. He graduated from Marshall College in 1928 and received the degree of M. D. at the Medical College of Virginia in 1932. He interned at White Cross Hospital, Columbus, Ohio, 1932-1933, and served as resident in that hospital, 1933-34. He was a member of the Cabell County, State, and American Medical Associations.

He is survived by his wife, Mary Louise Cullums Hayman, and three children, Paul Douglas, Jr., Lois Anne, and Patricia Sue.

HARRY BENJAMIN NEAGLE, M. D.

Dr. Harry Benjamin Neagle, 66, former Lewis County health officer with headquarters at Weston, died April 10 at Providence, R. I., of cerebral hemorrhage. He graduated from Johns Hopkins School of Medicine, Baltimore, in 1903. Besides his work in the public health field, he was at one time professor of preventive medicine at the University of Georgia Medical Department, Augusta. More recently he had served as epidemiologist in the state health department at Providence.

County Society News

CABELL

Dr. E. C. Hume, Professor of Oral Surgery at the University of Louisville, addressed a joint meeting of the Cabell County Medical Society and the Cabell County Dental Society at the Hotel Frederick, Huntington, May 11, at 6:30 P. M. He spoke on the subject of "Problems in Oral Surgery of Interest to Both Physician and Dentist."

COLE D. GENGE, M. D.,
Secretary.

KANAWHA

Dr. Howard Frank Root, who is associated with Joslin in the New England Deaconess Hospital (George Baker Memorial), at Boston, was the guest speaker at the regular monthly meeting of the Kanawha Medical Society, held at St. John's Parish House, Charleston, Wednesday evening, May 10. His subject was, "Diabetes in General Practice with Special Reference to Acidosis, Surgery and Experimental Alloxan Diabetes."

At the same meeting, Dr. Verne L. Lance, of Charleston, spoke on the subject of "Vague Throat Symptoms Due to the Elongated Styloid Process."

W. PAUL ELKIN, M. D.,
Secretary.

LOGAN

At the April meeting of the Logan County Medical Society, held Wednesday evening, April 19, at the Aracoma Hotel, Logan, Dr. E. E. Neustadt, of the Logan General Hospital, spoke on the subject of "Injuries to the Knee."

At the regular monthly meeting of the Society, held at the same place May 10, Dr. L. S. Salor, Acting Director of the West Virginia State Bureau of Venereal Diseases, discussed the purposes and function of the new Kanawha Valley Medical Center at South Charleston, with special reference to the rapid treatment method used for these diseases.

T. H. MILLMAN, M. D.,
Secretary.

MERCER COUNTY

At the regular monthly meeting of the Mercer County Medical Society, held at the West Virginian Hotel, Bluefield, May 18, an interesting film on the production and use of Lyovac (normal human plasma) was shown by a representative of the Sharp and Dohme company. Dr. M. W. Sinclair discussed and explained the operation of the Bluefield Sanitarium blood bank, and a full report of the meeting of the State Medical Association at Wheeling was made by Drs. David B. Lepper, Harry G. Steele and R. O. Rogers.

FRANK J. HOLROYD, M. D.,
Secretary.

Woman's Auxiliary

KANAWHA

A tea in honor of the new officers of the Woman's Auxiliary to Kanawha Medical Society was given at the Edgewood Country Club, May 9. Mrs. Scott A Ford, of Beckley, who was installed as president at the Wheeling meeting, was the honor guest. The tea was attended by fifty members and guests.

Mrs. Ralph S. McLaughlin, of Charleston, the new president, has announced committees for the year as follows:

Public Relations, Mrs. Paul R. Gerhardt; legislation, Mrs. Archer A. Wilson; Hygeia, Mrs. H. M. Mican; parliamentarian, Mrs. J. E. Rucker; visiting, Mrs. Ray Kessel; auditing, Mrs. Pat Tuckwiller; speaker's bureau, Mrs. Robert Price; press and publicity, Mrs. Francis A. Clark; historian, Mrs. W. E. Hoffman; bulletin, Mrs. T. P. Mantz; fellowship, Mrs. R. K. Buford; war record, Mrs. R. E. Pence.

HYGEIA CONTEST

The Woman's Auxiliary to the Harrison County Medical Society was one of the few county medical auxiliaries to reach or exceed its quota in the national subscription contest conducted by *Hygeia*, according to Mrs. Arthur I. Edison, national chairman. As previously announced, first prize in Group 3 (membership from 24 to 42) was awarded to Raleigh County. Mrs. A. C. Echols, of Layland, served as Hygeia chairman in that county.

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"BEYOND THE BLUE HORIZON"*

By ROBT. J. REED, JR., M. D.
President, West Virginia State Medical Association
Wheeling, West Virginia

Not so very long ago, I was having lunch with the chairman of the Scientific Committee and our able secretary, Charlie Lively. The final arrangements for our meeting were being made. Everything was going fine, an excellent program had been arranged, and we all were in the best of spirits. At this point, Dick Gill turned to me and said, "Robert, here is your program; all is complete with the exception of one little item, the subject for your great presidential address—what is it?"

To propound such a question and to disrupt such happiness was indeed most unfortunate, for all our joy turned to gloom when I said, "Well, really I haven't the slightest idea." At this point Charlie became most perturbed. "Surely, Mr. President, (Charlie is always so deferential) you must know that not only your subject, but the paper itself, must be in my hands within the next three days. It must be reviewed and sent to the publishers for reprints." "Now wait a minute, Charlie," I said, "forget about the publishers and the reprints. In the first place there is no sense in making reprints of this or any other presidential address, to be handed out to the members as has been done in times past. It is a waste of money and good white paper, and in the second place I doubt if any member reads one of these reprints, especially if he has just listened to the rendition of same, from the lips of the author himself."

Well, strange to relate, Charlie seemed right pleased. He agreed heartily that it was a waste of money, but he did insist that he know my subject by the following Tuesday. So I thought and I thought, but my mind grew progressively duller. It was not until late that night—I had given up thinking from sheer exhaustion, and for want of something better to do, began humming the tune of an old song, when lo and behold a title was born, "Beyond the Blue Horizon."

THE AUTHOR

Dr. Reed, graduate University of Pennsylvania School of Medicine; interned University Hospital, Philadelphia; Fellow American College of Surgeons; Surgical Staff, Ohio Valley General Hospital.

Annual Address of President, West Virginia State Medical Association, 77th Annual Meeting, Wheeling, West Virginia, May 15, 1944.

Now some of you old song birds probably remember the tune. You may not have sung it as often as you've sung "Sweet Adeline," but at least you remember it. For the rest of you who may not be acquainted with it, I will repeat the chorus—you will forgive me if I refrain from bursting into song: "Beyond the blue horizon waits a beautiful day; Goodbye to things that bore me, joy is waiting for me; I see a new horizon, my life has only begun; Beyond the blue horizon lies the rising sun."

BIG BUSINESS

These are the words of just one of the thousands of popular songs that have been published within the past few years, but how truly they describe the feelings of most of us today. I'm sure all of us are bored and tired unto death with the turmoil and the talk of socialized medicine. We would like nothing better than to go our way, practicing our profession as best we can, hoping, ever striving for perfection. Our minds should be devoted entirely to the ever improving scientific aspect, and the all important art, in the practice of medicine. In place of that we must become lobbyists, politicians, speech makers, economists, and a host of other undesirable things, all because the old practice of medicine, as our fathers knew it, has changed, and now has become big business. We cannot deny this, we know it to be true, but apparently we cannot help it. To be sure, there are still many of the old school, God bless 'em, practicing for the most part in small communities, who render a valuable service with little financial gain, their chief compensation being the love and devotion of their humble patients. These people still consider the family doctor next to the Almighty Himself, and he, as has been so tritely said, will receive his just reward in Heaven. This small group is fast disappearing for two very good reasons. The old doctors are dying off and young doctors with certain financial obligations are not replacing them. This, then, is the first big problem that we have been unable to solve, so the government proposes to solve it for us.

But to get back to big business. With the advances in the practice of medicine more hospitals were needed, and many clinics and huge medical centers were established. Individual doctors, practicing either by themselves or in groups, needed more space and more equipment. All this and much more added up to only one thing—an outlay of vast sums of money, to say nothing of a tremendous daily overhead. Who was to pay for all this? There was only one answer: "Johnny Q. Public." This was all right for the well-to-do, they liked it and they could afford it. It wasn't half bad for the indigent. The Almighty, with a little help from the doctors and hospitals, always seemed to look out for the poor. But the fellow in between—he was in a fix. So for years we have heard the cry: "inadequate medical service for the poor and needy," and "complete medical and hospital coverage for the wage earner at a reasonable rate." To say that we heard the cry does not necessarily mean that all the various and sundry cries were true. The medical profession as a whole has always rendered able and necessary service to the poor, free of charge, but the social workers and other lay groups kept up the cry: "inadequate medical service."

LOW INCOME GROUP

The wage earner in the low income group probably has had a justifiable complaint. I'm sure most of us have felt that the very slight difference in the fee charged to one in this group, and let us say his next door neighbor in a much higher group, was not commensurate with his ability to pay. Thus was set in motion various plans to bring a more adequate and complete medical coverage to large groups at a low cost, principally by deduction from wages. We saw the beginning of this in the coal fields of West Virginia. Then, industrial plants all over the country inaugurated plans for complete medical and hospital coverage by the employment of physicians on a full time basis, and we have listened to the glories of Mr. Kaiser and his plans "ad nauseum," as if no other industrial group had ever thought of such a thing until Mr. Kaiser came along. In West Virginia, for example,

there is a plan that has been in operation for several years in the southern end of the state which, I believe, has proved most satisfactory to the patients, the doctors, and the hospitals, and which, as I understand it, is as ethical as any such plan can be. There are many other plans throughout the state, some under the control of a particular industry, others privately controlled, while still others are under the control of the local medical society. In times past, our life has been quite full, condemning or criticizing one plan or another, on the basis of ethics. My worthy predecessors have done a fine job smoothing out the many wrinkles on our otherwise fairly comfortable bed, and more recently our Fact Finding Committee has worked hard and diligently, striving earnestly for the answer, and to make recommendations that would be acceptable to the profession and the public.

PRIVATE INSURANCE

In spite of all this, these plans have touched merely a handful of the population. The vast majority of the people in these United States were not covered, and they were demanding some type of coverage. Private insurance companies, after a great deal of deliberation, finally went into the field selling hospital insurance with a modicum of medical coverage, and we began spending a part of our time filling in blanks, and cursing the companies for indicating what our fees should be. Then came the nonprofit plans for hospitalization which have been generally adopted in many communities, but never without a struggle.

Now, you would think with all these plans in operation the vast majority of the people would be satisfied, but the crux of the situation has not been reached; these people are still without low rate, prepaid coverage for medical services, and this is where the doctors have been in slow motion. Perhaps the effort has been too great, perhaps the problems have been too complex, perhaps we have had poor leadership from the powers that be in our profession, perhaps no one has shown us an easy, ethical way, and because we have been slow some able politicians have declared that the government will do it for us. Here then, dear friends, "endeth the first lesson," but here also, my stalwart brethren, beginneth the new day in our profession on which, if we are able to surmount the barriers and can direct ourselves as well as the public (our patients) in the right paths and up the high slopes of public opinion, we will reach the summit of the mountain, and there "beyond the blue horizon" behold the glories of a new and a better day.

BILL NO. 1161

How then must all this be accomplished? First, I will say, not by damning Bill 1161, or any subsequent bill that may be introduced at Washington, but by offering a better substitute to the public—one they will heartily endorse and one wholly acceptable to, and governed by, our profession. I certainly do not propose to discuss 1161 in this paper; it is a rag that has been wrung dry for some time. However, I would like to point out that destructive criticism is very apt to rebound in one's face, while constructive criticism, unless offered to one's wife, will reap rewards of gold. We have been informed by a recent survey made by the National Physicians' Committee that 63 per cent of the American people want an easier method of paying the costs of an unusual or prolonged illness; that only 16 per cent approve a 6 per cent payroll deduction for the federal government in order that it may provide medical care and hospitalization; or, in reality, if we put these two groups together, 79 per cent of the people want some easier way to meet medical and hospital bills. If this information is accurate, then something very definite must be done. I think it is safe to assume that 1161 in its present form will be defeated. It is not safe to assume, however, that because of this defeat a similar or modified bill will not arise and be passed, unless we as a whole act very promptly to establish widespread plans for the medical care of these dissatisfied people.

Let us begin our reasoning on the premise

that there will be always in this country the private practice of medicine for those who desire it, and are willing to pay for it; but let us further assume that there are great hordes of people in this country who want adequate and competent medical care, and who would prefer the physician of their choice, but if this were not always possible would accept an equally competent physician. Assuming this, I am afraid that we have obeyed the law of the jungle—the law of self-preservation—a little too long, and though we like to think that we are the indispensable man to our patients, they frequently get along very well with someone else. It is, then, to these people that I would suggest a plan which, in its offering is sketchy as to detail, but which, if considered in its entirety, would solve, I believe, the vexing and difficult problems with which we are now faced.

MEDICAL SERVICE CENTER

I would propose that there be established in each county or community all over the country, an organization to be known as the Medical Service Center, under the control of the local county society, or groups of nearby societies, which would render service to all who wished to come within its doors. All members and their families would be charged the same annual rate, depending upon the size of the family, and the county, state, and federal government would pay in just proportion the same rate for an individual or family who on investigation was found to be indigent. This one thing I want you to bear in mind: that all patients, no matter how high or low in life's scale, passing through the doors of this Center, would be on an equal footing, and would share and share alike in its benefits.

Now, to start this plan let us take a single unit and develop it. The first thing to be accomplished would be the approval of such a plan as will be outlined, by the local, state and national societies. The second thing would be the approval of the county, state and federal government for allocation of such funds as would be necessary to take care of the indigent, as has been done during these past few years for the care of these people. After these two items were accomplished, perhaps with some difficulty, the organization of the Center would begin. This would include the raising of money for the construction and the equipping of such a Center. All members of the society would be eligible to serve and would be expected to serve in this unit, although it would not be obligatory. A board of directors composed overwhelmingly of doctors, with a smattering of laymen representing hospital boards, would be established, and would, of course, be the governing body of the Center. A full time medical director would be selected. The managing director of the local hospitalization plan would have his quarters in this unit, and if such a plan had not been already established in a community, it would become organized along with the medical plan. The personnel of the Center, beside the medical and managing directors, would be composed of doctors serving full and part time—members of the society, or young doctors who may have recently finished an internship or residency, or who may have returned from the armed forces, but had not been in the community long enough to become eligible for membership in the local society. This latter group could participate only upon invitation from the board of directors. The full time operating personnel would consist of a skeleton force of doctors representing all the special branches of medicine and surgery, nurses, laboratory technicians, clerical help, et cetera. Doctors on part time would be expected to serve on certain specified days, and these men would compose the largest medical and surgical group.

METHOD OF OPERATION

The modus operandi of the organization would be about as follows: A patient would come to the Center. He would ask to see a certain doctor, who had been his family physician. If this doctor were available he would be ushered into his presence, but if not available he would be told that his doctor

was at the Center only on certain days, that if he desired he could see someone else, or return when his doctor was available. Let us assume for sake of argument that he has seen the doctor of his choice, that his doctor desired certain special examinations; the patient would then be referred to other services for further study as is done in all medical centers and clinics. If, after careful study, he should be found to have appendicitis, diseased tonsils, or some other equally rare condition, an operation would be suggested, and he could then have the surgeon and hospital of his choice, so long as the surgeon is a participating member of the Center. The same, of course, would hold true for all other cases that might require hospitalization—medical cases, obstetrical cases, et cetera, the patient always having a free choice of doctor and hospital, provided the doctor is a participating member of the Center. The reason for this last is obvious. The doctor, whether serving full or part time, must be on a fixed salary and the salary paid would be in proportion to his ability, and the extent of his services rendered. If the patient should not wish to make the choice of a surgeon, he would be sent to the man best qualified to handle his particular problem, or the work should be divided equally among the men available, or he would be sent to the man attached to a certain service in that particular month; details such as these would have to be worked out to the satisfaction of all concerned.

HOUSE CALLS

Another item of vast importance is the one pertaining to house calls, especially those pleasant calls received between 2 and 4 a. m. It is my present belief that house calls should not be included in the patient's contract, but should be paid separately by the patient to the doctor at a fixed and standardized rate. I believe that the Center should have a few men available at all times, especially at night, who would be expected to make these particularly annoying but sometimes very necessary calls. All calls should come into the Center itself, and it would be up to the operator on duty to see to it that some doctor is dispatched post haste. This, in brief, is an outline for a plan, which in itself is not new. It is just the adaptation of the outpatient department idea in large teaching centers, to centers all over the country, run on a business basis under the control of the local society, with the patients paying a fixed annual sum for services rendered, supplemented by state or federal aid for the indigent; but it does provide in addition, an opportunity to retain the personal relationship of physician and patient. If the contracts were abused by the patients, such as the demand for more than adequate service or the making of unnecessary calls, they could be terminated by the board of directors. Likewise, should certain doctors abuse their trust or show lack of interest, their resignation could be requested. Remember, this would not be a charitable organization, but an extensive medical service plan with the doctors receiving adequate compensation for their services.

ORGANIZED PLAN

I am satisfied that some highly organized plan, perhaps similar to this, is the safest, surest and quickest way to combat the day by day trend toward socialized medicine. I am not critical of the plans that are now being attempted in various communities, and under the control of the local medical societies, where fee schedules are set up; in fact, I feel that the societies are to be congratulated on taking these steps. Surely they are making a noble effort in the right direction, which is much more than can be said for the rest of us. There is only one thing that is important. Something must be done all over the country, and it must be done in the near future. There is no time for experimentation. What we want is a plan that will work. The federal government is getting closer to our doors day by day, and once it gets in the house, we might as well get ready to spend the rest of our days in the attic.

And now I would like to send a message to our men on the fighting front, and to those in the armed forces wherever they may be:

You have been called to serve your country in its most critical hour. You have left your home and loved ones, your patients and your practice, at a time when things began to look the brightest. You were becoming well established in your community. Your going was a great personal sacrifice, but you went willingly, not just to serve a cause, but to save, if possible, the minds and bodies of men racked by the destructive forces of war. You have done, and will continue to do, a grand job. Without you there would be no victory. With you and our forces, rests the hope of an everlasting peace.

SERVICE DOCTORS

For those of us who have remained at home, many of whom have gathered here tonight at this, our seventy-seventh annual meeting, I send our warmest and most sincere greetings. But in addition to this, I send our pledge, that in so far as is humanly possible, we will attempt to preserve at home the democratic ideals for which you are so nobly fighting, which include in no small measure of importance, the free and independent practice of medicine. Let me further assure you that the patients you left behind, though temporarily under the care of one or another of us, have retained their loyalty and devotion to you and look forward eagerly to that day, when, upon your return, they may go back to you, grasp your hand and say, "Thank God, you, my doctor, have returned." You may have read or heard discussed the so-called problem of the returning doctor after the war. Believe me, men, when I say there is no such problem. You not only will begin where you left off, but, with the advantages and the practical experience that you have had, you will be so far in advance of most of us "old doctors" that I fear we will be forced into the proverbial back seat. When I say there is no problem, I refer particularly to you men who enjoyed the private practice of medicine before the war. For the men who went directly into the armed forces from medical schools, or from a brief sojourn as an intern in a hospital, there is something of a problem, but it is not a serious one. The first thing to remember is that there is always room, any place, for a good doctor. The second thing is that if you wish to specialize, many residencies and other opportunities for postgraduate training will be open to you. Thirdly, if such a plan as I have just recently suggested could be universally adopted, there would be a job waiting for all of you. You could serve either full or part time, allowing yourself to become established in the community of your choice, and at the same time beginning the building of your fortune, which, sad to relate, no one of us will anymore achieve.

But men, don't think for a minute that the old practice of medicine at home is falling apart. It isn't. It may be receiving a few jolts but it may be also receiving a good shot in the arm. You could be of great service to us here at home if you would send us your ideas on how you wish to practice your profession when you return. Do you look forward to again taking up the practice of medicine as an individual, or do you feel that you have found satisfaction and happiness in an organized group? We would like to know how you feel, so that we may be guided in our work and plans for the future of medicine.

CONCLUSION

As I write this last paragraph I'm thinking of an old pal of mine, now in the South Pacific. We have gone fishing together on the same old lake in Canada for a number of years. I wonder if you too have had a similar experience.

Have you ever been out in the early morning, sitting on a wet seat in a dinky row boat, the mist being so thick that you could hardly find your favorite spot in the weeds to fish? But you finally got there and found the bass feeding fast and furiously, striking your fly, or bug, or whatever was your favorite lure or bait. You didn't mind the cold or the wet. You were a king in your own right, and you were having a whale of a time. You stopped for a moment to get your breath, to light a cigarette, to pinch yourself to make sure that

this wasn't just a dream. You looked about you, the mist was rising, far out in the east you saw the sun coming up like a great golden ball; as it rose in the heavens it seemed to drive the fog and mist away, and before you knew it, you'd forgotten the fish that were so recently splashing about you, for you had been transfixed by the glories of the dawn.

And if by chance you were out on that same lake the preceding evening, you saw a hot sun settle in the west; you saw magnificent colors in the sky; you saw a blue horizon; but you saw too, a day that was done. Yes, it was depressing; it had been a glorious day! You had tried to make the most of it. Then as the night settled down slowly upon you, and you were ready to give up the ghost, you became thrilled with the anticipation of the morrow, as you contemplated the rising sun of a new day.

NEWER TRENDS IN THE MANAGEMENT OF UPPER RESPIRATORY TRACT INFECTIONS*

By A. R. HOLLENDER, M. D., F. A. C. S.
Chicago, Illinois

MEDICAL science has failed thus far to discover a specific remedy for the common cold. It is doubtful, furthermore, whether a specific form of therapy will ever be discovered. The intrinsic and extrinsic factors which enter into the problem are so numerous that our therapeutic approach must remain along symptomatic lines. We can, however, accomplish considerable by prophylaxis, aspects which have failed to receive the attention they merit.

PROPHYLAXIS

It is common for us to instruct persons susceptible to colds to maintain a high state of resistance, a term synonymous with a high standard of health. Exposure is ineffective in the production of colds when the individual's well-being is up to par. It has been my experience in studying the problem that cold-susceptible persons are those who basically suffer from some other bodily ailment, eat poorly and irregularly, keep late hours and otherwise violate the accepted laws of good personal hygiene. Even in susceptible infants and children do these violations hold true, but in them the nutritional factor is of greater significance. Prophylactically occupational pursuits merit serious consideration. Certain occupations require undue exposure, undermining the health so that this predisposing cause plays its rôle.

THE AUTHOR

Dr. Hollender, graduate University of Illinois; Associate Professor of Laryngology, Rhinology and Otology, University of Illinois College of Medicine; Acting Chief of Otolaryngological Service, Illinois Research and Educational Hospitals; Amercian Academy of Ophthalmology and Otolaryngology.

Seasons are of some significance in certain areas. In the north, for example, colds are fewer in the summer months, increase with changes in the weather in the fall, and reach their peak in incidence and severity during the winter months. In the south, even in semitropical and tropical climates, much the same situation obtains because of the migration of infected individuals to this area. Keefer,[1] as well as other investigators, has stressed that the introduction of the virus from outside is more important than the climate. It should not be overlooked, however, that colds in persons who live in or go to tropical areas are no less severe than those occurring in colder climates. The course of the infection and the likelihood of complications will depend on the patient's ability to increase his resistance.

The immunologic aspect of the common cold is of major importance. Keefer has

*Presented before the Kanawha Medical Society, Charleston, West Virginia, February 8, 1944.

FOOTNOTE—From the Department of Laryngology, Rhinology and Otology, University of Illinois College of Medicine.

pointed out that a certain degree of immunity, as judged by resistance to infection, develops as a result of a cold, but it is of short duration. Paul and Freese[2] estimated that the period of immunity in the human is not less than 23 days, with an average of about seven weeks.

Recent claims have been made that allergy is occasionally responsible for upper respiratory tract infections. Allergy may be a related cause, but in my opinion, it is associated with the vasomotor changes often seen and confused with other possible causes. Experimental evidence proves that sudden chilling of the body is capable of altering a red nasal membrane to one of pale, anemic color. Is it allergy, that is, a physical allergy which is responsible for this change, or a strictly physiologic process due to some other cause outside the domain of hypersensitiveness? Is it likely that the nasal allergic process is founded on a vasomotor basis? We cannot answer these questions satisfactorily, since the many ramifications of the problem would carry us far afield. Suffice to say that chilling of the body is an important etiologic factor in the activation of respiratory infections, and that physical allergy, especially as to cold, must be seriously considered from the same point of view.

The prevention of colds has been unsuccessfully attempted by various methods. The one which has been tried for several decades is by vaccines. Most physicians and lay persons are familiar with the so-called "cold shots" which have failed to come up to expectation. The oral vaccines are still in the experimental stage. It is difficult to judge their merits even in so-called controlled studies. Walsh[3] believes that the rational method against so "local" a disease as a cold is by the topical application of vaccine to the nasal mucosa in the form of a spray. Diehl, Baker and Cowan[4] studied the problem of vaccines generally and became convinced that the results are insufficient to justify the time and expense involved in carrying out an intensive course of vaccination.

Like vaccines, vitamins also have failed in the prevention of respiratory tract infections. They may have a tendency to increase the general resistance of vitamin-deficient individuals and thus indirectly render them less cold-susceptible, but to claim more than this would be exaggeration.

The time-honored hardening processes suggested by Keefer and carefully investigated by Gafafer[5] have, like all other procedures, proved a failure. The latter was unable to show any lower incidence of colds in persons who followed certain practices, such as cold shower baths every morning and exercise outdoors followed by hot and cold shower baths.

Lastly there should be considered the effect of nasal medication in preventing the common cold. The older preparations—the silver protein solutions, are not only valueless but definitely hazardous if used constantly over indefinite periods. The newer sulfonamide nose drops are likewise useless as a cold preventive. They, too, may produce untoward reactions not unlike those of an allergic rhinitis.

It must be confessed that the prevention of the common cold remains a problem for investigation. Until such a time as some effective plan shall be suggested, we must content ourselves with the institution of measures that influence one's personal hygiene, maintain physical resistance at a high level, and avoid the extraneous elements capable of producing vasomotor symptoms.

GENERAL CONSIDERATIONS

Once the upper respiratory tract becomes acutely infected, it is possible theoretically, at least, to abort the disease. Practically the results nearly always fall short of success because of two problematic factors, namely:

1. Does the infection originate in the tract itself?

2. Is it a manifestation of some cryptogenetic involvement?

If we could answer either of these questions with some degree of confidence, the therapeutic approach would be simple. Since

we cannot, and the etiology remains undetermined, the general or systemic treatment is empiric and uncertain. The local treatment, on the other hand, is not instituted as a curative, but for symptomatic relief which it is capable of affording. In reality local therapy is purely physiologic therapy, more certain in its effects and final results.

Aside from these general considerations, it is essential to ascertain whether the infection is primary, or an exacerbation of a latent infectious state of one or more of the paranasal sinuses. So-called frequent colds are not always new attacks. More often they are merely repeated exacerbations of an uncured sinusitis which lights up at the slightest provocation. Meakins[6] calls attention to individual susceptibility or predilection to attacks of acute rhinitis and holds that this may be due to an allergic condition. "On the other hand," he states, "it is frequently due to a chronic infection of the paranasal sinuses which from time to time becomes active, reinfecting the mucous membrane of the nose and nasopharynx, really producing exacerbations of an already existing chronic infection. Such recurring acute attacks will probably continue as long as the chronic infection remains."

Let us now consider the general and local management of respiratory tract infections.

GENERAL MANAGEMENT

Acute Infections.—The general treatment of acute upper respiratory tract infections is, in my opinion, more important than any topical applications to the nasal mucosa, in spite of its uncertainties. Some comment has already been made about prophylaxis, but sufficient has not been said about avoiding contact with infected persons and congested places. If we are dealing with a patient who is suffering from frequently recurring "colds" due to exacerbations of an already existing chronic infection, a cure will not be possible until the focal disease is eradicated. Every conservative means should be tried before radical procedures are instituted, but it is logical that in the presence of a chronic focal infection general treatment alone will be of no avail.

Previous reference to abortive treatment was merely suggestive. While usually measures are not instituted sufficiently early to be effective, bed rest in the incipiency of an attack is most essential to shorten the course of an acute infection. Catharsis is not indicated unless constipation exists, but even under such circumstances elimination should be promoted by enemata and not by drugs.

As in the abortive treatment, so in the active, bed rest is the first step to be considered. Rest is a physiologic measure, probably of greater value than any form of medication. The nutritional aspect is the second step to receive attention. The diet should be rigidly restricted, especially if there is an elevation of temperature. In the event a dietary deficiency exists, vitamins may be administered until such a time as the patient is able to partake of a well balanced diet. In some cases large doses of vitamin C (cevitamic or ascorbic acid) seemed to be beneficial in ameliorating the symptoms. As much as 500 to 1,000 mg. a day for one or two days should be administered if a prompt effect is sought from this product.

ADMINISTRATION OF DRUGS

The third step consists of the administration of drugs. Of these, acetylsalicylic acid, a papaverine-codeine combination and the sulfonamides merit trial. If acetylsalicylic acid is prescribed, it should be given in large doses administered over a short period. In my experience, six doses of 15 grains each for the first two days are more effective than 18 doses of five grains each administered over four or five days. The dosage of the papaverine-codeine combination should be one-fourth grain of each drug given every three hours for one or two days as indicated by the symptoms. In addition, cevitamic acid, as mentioned previously, may be administered without conflicting action.

As to the sulfonamides, they are of little or no value in the virus types of infection of the upper respiratory tract. They may, how-

ever, have some favorable effect on the residual disease caused by secondary invaders. In all cases of respiratory tract diseases in which a complication is impending or already present, administration of the indicated sulfonamide preparations is strongly advocated. In some cases of acute sinusitis the sulfonamides have given favorable results, often obviating the necessity of local measures. In a controlled study of some 30 cases of acute sinusitis, chronicity and complications were less frequent by 30 per cent in the group which received sulfadiazine as compared with the one which was treated without the oral administrations of this drug. It must, however, be given early with the patient under bed rest control. The same rules apply here as in all instances when sulfonamide preparations are administered.

No rational or successful therapy can be instituted without first demonstrating the relationship of allergy, if suspicion of such a possibility exists. As this pertains to diagnosis, it is mentioned here only as a postulate of sound therapy. Whether an allergen is demonstrated or not, one should not remain content with immunization, but correct any existing pathologic state, focal or otherwise. Symptomatic treatment should be afforded the patient without delay.

The main therapeutic problem lies in viewing the patient as a sick being and not merely as a diseased nose to which the body happens to be appended.[7] Without knowing the true systemic state of each patient, local therapy and allergic therapy combined will fail in many instances.

The temporary treatment which nearly every allergic patient requires for palliation is of necessity nonspecific. Resort must be had to drugs and to local and general procedures. In acute upper respiratory tract infection, foreign protein therapy has been, and still is, highly regarded by some physicians. It should be stated as a warning that preparations capable of producing severe shock in allergic-respiratory diseases are not only unnecessary but dangerous.

Chronic Infections.—The general treatment of chronic rhinitis should be directed toward the underlying etiologic factors. Metabolic and endocrine factors should be sought for and corrected. Deficiencies should be met by regulation of the diet, heliotherapy and general hygienic measures. Not all persons with a postnasal drip suffer from sinus infections. In fact, in not a few cases the cause is constitutional rather than local. The rhinologist must not lose sight of this fact and follow the single track—topical measures—without giving the patient the maximal effects of systemic therapy. In infants and children with chronic rhinitis or chronic nasopharyngitis, the cooperation of a pediatrician to investigate and treat the general aspect of the problem is of paramount importance. In adults the internist can aid in searching out any existing constitutional defects. Only by such collaboration can the proper program of general management be undertaken. In the meantime the rhinologist can apply such local measures as are indicated. If after a reasonable period continued local and general treatment fail to influence the symptoms, a change of climate should be ordered. It is often amazing how promptly chronic rhinitis will clear up when the patient moves his permanent residence to a uniformly warm and sunny climate. Southern Florida, northern Texas and certain parts of Arizona have proved a haven to chronic sufferers from upper respiratory tract disease who have failed to respond to the usual methods of treatment. This does not, however, necessarily apply to patients with chronic sinus involvements. Too many of these persons are disappointed with climatotherapy, because in it they sought to evade proper management of the sinusitis itself.

NASAL MEDICATION

Since the nose is the main entrance to the upper respiratory tract, efforts should be directed to the treatment of the nasal mucous membranes. During the acute attack nasal medication should not be employed unless the patient is so uncomfortable that sympto-

matic relief becomes imperative. Our knowledge of nasal physiology has advanced to the point where only certain medicaments are properly indicated. Having in mind the underlying principles of all nasal therapy—the improvement of ventilation and drainage—the indicated medicament is one that will shrink the mucosa and at the same time not disturb its physiology. The older cocaine preparations for obvious reasons are no longer used, since ephedrine and various synthetic ephedrine preparations have become available. The ideal astringent is one that will shrink the membrane for the longest possible period and at the same time prove nonirritating. During the attack of acute rhinitis the astringent effect on the mucosa is considerably reduced irrespective of the preparation applied, in contradistinction to the effect on a normal membrane with the same medicament.

Fabricant[8] studied the pH of the nasal secretions in situ and emphasized that acceptable therapeutic measures for acute rhinitis produce uniformly a single pH phenomenon—acidity. He summarized the results of his investigations thus: "The course of the nasal pH is altered by the application of either cold or heat. Cold produces a drift toward alkalinity, heat a drift toward acidity. * * * It is suggested that during an attack of acute rhinitis or acute rhinosinusitis the employment of a nasal vasoconstrictor, such as 1 per cent ephedrine hydrochloride in saline solution, which lowers the alkaline pH to an acid level between 5.5 and 6.5 is most desirable."

It is obvious from this that the older medicaments which were applied for their alleged antiseptic action are no longer logically indicated. The objective at all times should be to preserve or restore the normal defensive mechanism. Antiseptic preparations instilled in the nose have little or no effect on the infection itself, while in most instances they produce a destructive action on the mucous membranes.

The use of ephedrine nose drops combined with one of the sulfonamides has become quite popular. Patients now insist on "sulfa nose drops." Various combinations of vasoconstrictors and sulfathiazole have been stabilized and are on the market. It is questionable, however, whether the sulfonamides have added any effective action to the vasoconstrictor solutions.

Fabricant's[9] recent comment on the use of nasal sulfonamide preparations is timely: "Such factors as the effect of a nasal medicament on the mucous membranes of the nose and sinuses, its relationship to ciliary action and nasal pH, and the degree of toxicity which is sometimes produced by absorption from the mucous membrane are always of propitious consideration in establishing the value of a nasal preparation. The fact that alkaline preparations of sodium sulfathiazole injure the mucous membrane is sufficient to indict them on that score." In justice to this subject it should be stated that not all of the sulfonamide nose drops are of the high pH indicated by this author. Whether some of them will ultimately prove sufficiently efficacious to warrant their continued use remains to be seen. The physician should be open-minded and observe future reports before accepting premature conclusions. As for myself, I have utilized several of the newer preparations, especially the microcrystal suspension of sulfathiazole suggested by Silcox and Schenck.[10] However, since the solution used consisted of combining sulfathiazole with a nonirritating vasoconstrictor substance—a 1 per cent aqueous solution of paredrine—it has been extremely difficult to evaluate this preparation. As has been intimated before, whatever favorable action is obtained may be due entirely to the vasoconstrictor solution.

Silcox and Schenck noted that the microcrystals disappear completely from sinus cavities within four or five days, either by ciliary movement or by absorption, and were found to be diffused over the surface of the membrane rather than deposited in one area as a powder. Inasmuch as the common cold is the forerunner and background of virtually all

types of bacterial disease of the sinuses, and inasmuch as the secondary invaders which actually produce sinusitis are the streptococcus, staphylococcus and pneumococcus, these investigators contend that the application of a preparation which is specific for these organisms should be the method of choice to prevent the development of sinus infection, or to treat it when it has become established.

It is interesting to note that measures other than nasal medication are capable of acidifying the nasal secretions. Some years ago I[11] advocated infra-red radiation to combat acute infection of the upper respiratory tract. On the basis of some experiments I concluded that external heat to the region of the nose and accessory sinuses produced some sort of chemical reactivity, but beyond this I was unable to explain why improved results occurred. Now, Fabricant in his studies, has shown that when external heat is employed, singly or combined with adequate rest and sleep, the end result is essentially the establishment of an acid nasal therapy.

NASAL THERAPY

A further advance in local nasal therapy is the method by which medicaments are applied to the membranes. No longer is it scientifically correct to drop medication in the nose without regard for the patient's posture during the procedure. Proetz[12] and Parkinson[13] have stressed that the most favorable results in upper respiratory tract infections are obtainable with vasoconstrictor solutions applied by rational postural methods. Proetz's technic of displacement is sound physiologically, while Parkinson's method of nasal instillation is reactional anatomically. These postural technics are the ones in vogue which have proved most satisfactory, since with them nasal medication has become a scientific procedure.

Some authors have recently advocated the intranasal insufflation of the powdered form of the sulfonamides. Connell and Trowbridge[14] believe that this method is superior to the instillation of solutions and avoids some of their hazards and harmful effects. This has been definitely borne out in some instances. I have succeeded with this method in curing several patients who have suffered from protracted cases of nasopharyngitis which have resisted other procedures. Both Freeman[15] and Fenton[15] have reported favorable results from the local use of sulfathiazole in the nasopharynx.

ACUTE SINUSITIS

Sinusitis is usually a complication of acute rhinitis. It may, however, occur as an exacerbation of a latent or uncured involvement of one of the paranasal cavities. In general the treatment of acute sinusitis differs little if at all from that of acute rhinitis. I have already referred to the results obtained with the sulfonamides in acute sinusitis. Why these chemotherapeutic drugs should prove effective is easily explained. As a general proposition when the infection reaches the sinuses it is no longer of the virus type.

In sinusitis as in rhinitis the resistance of the individual must be given first consideration and in this connection the nutritional aspect must not be neglected. Rest, a well balanced diet, and the administration of drugs for the symptomatic relief of pain are in order. Topical medication should be postponed until the disease passes into the subacute stage. If, however, nasal blockage causes great discomfort, the instillation of one of the isotonic vasoconstrictor solutions and the use of the infra-red lamp over the facial region several times a day are often desirable.

In the subacute stage of sinusitis nasal medication by the postural methods is indicated. When chronicity impends and purulent secretions require mechanical removal, I employ the siphon method. With this procedure irrigation and suction are combined. Patients submit to this without hesitation. Its continued use is not to be recommended, but for the purpose of occasional mechanical cleansing, it is highly advantageous. The patient is then in better shape to benefit from the displacement treatment as advocated by Proetz, or from other local methods.

When a single sinus is involved and there is evidence of retained purulency, irrigation of the single cavity is definitely indicated. In our clinic lavage is performed in most cases through the natural ostium. There are some cases, however, in which the trochar method must be employed. Repeated irrigations of the nose and sinus cavities are objectionable because they add insult to injury. Waterlogging of the membranes frequently results, retarding the healing process by maintaining a state of devitalization of the tissues. I have personally observed numerous cases of sinusitis which persisted in discharging because of these facts. As soon as the irrigations were discontinued, the discharge ceased and cure took place. There is only one indication for lavage—mechanical cleansing. Healing of a sinus membrane will usually occur when the physiology of the nose and sinuses is restored.

CHRONIC SINUSITIS

If surgical intervention in sinus disease is indicated at all, it is indicated in the chronic stage. But even here the most conservative procedures often prove to be all that are required. The pendulum is swinging away from radical sinus surgery. Certainly the results from radical sinus operations are no credit to the profession. The explanation for the conservative trend is not based solely on clinical grounds. The advances in allergy, in nasal physiology and the more plausible evaluation of possible changes which take place in tissue subjected to infection readily account for our departure from the destructive effects of radical operative intervention.

In the correction of pathologic processes in the nasal sinuses, the endeavor, as far as possible, should be to conserve normal function of structures, or to restore or repair them when they become involved by infection. There are a number of rhinologic measures which strikingly show the differences between those that are purely mechanical and those that are biologic.[17] The former are characterized by destruction, impairment or abolition of function, while the latter typify the surgical ideal of biologic conservation. These newer physiologic principles render a departure from the older technics in rhinologic surgery highly essential to obtain improved end results.

The principles underlying the management of sinusitis are no different today than they were decades ago. Ventilation and drainage when interrupted or interfered with by bacterial infection must not only be reestablished, but maintained. The question arises: "Does a destructive surgical procedure like extirpation of a sinus membrane furnish the means necessary for the reestablishment of a normal sinus?"

RADICAL SINUS OPERATIONS

It is our belief that most radical sinus operations are anachronistic. Conservative medical and surgical procedures seem to be adequate in the large majority of cases. Our present deductions concerning the fallacy of radical operations in nasal sinusitis are the result of microscopic studies of large numbers of specimens of extirpated sinus mucosa. Our interpretation of the histopathology of sinus mucosa differs from that of most workers in that we do not consider most extirpated sinus membranes as being irreparably diseased.[18] We believe these membranes possess the capacity of repair, if and when favorable conditions are established, principally adequate ventilation and drainage, by proper attention to the sinus ostium. Nature will then carry the sinus mucosa through the process of healing as it does any other body tissue. Unless proof can be established that the mucosa has passed beyond the stage of recuperation, its removal is not justified. We do not include in this category highly hyperplastic involvements and other absolute indications for radical extirpation, for it should be borne in mind that our subject embraces only inflammatory processes.

The outcome of an infection of the body will depend in a great measure upon the resistance of the host and the virulence of the offending organism. From another point of view we recognize that tissues have the capacity to rid themselves of the products of

inflammation. A good example is a deep abscess signifying on one hand a winning battle, and on the other a problem of prompt and assured healing by maintenance of external drainage. This latter fact is especially illustrated in inflammation of the nasal and sinus cavities which are constantly cleansing themselves and performing their respiratory function by means of a mucociliary sheet. The poor anatomic position of the sinus ostium is no barrier to this sheet as has been repeatedly shown in the past. At all times the proper functioning of the sinus mucosa is intimately related to the drainage pathways of the nasal and sinus spaces.

In a given case of sinusitis, unless the prognosis can be made with reasonable accuracy when radical operation is advised, it is far better to resort to less drastic procedures. It should be repeated that most sinus membranes are not irreparably "diseased" as usually interpreted. It would be more accurate to label them "reparative" or "resisting" membranes. Finally it should be emphasized that the prognosis of nasal sinusitis would be greatly enhanced by strict adherence to conservative therapeutic principles.

SUMMARY AND CONCLUSIONS

1. Medical science has failed thus far to discover a specific remedy for the common cold.

2. While theoretically prophylaxis and prevention remain the ideals for reducing the incidence of colds, efforts at prevention through immunization and other procedures have not met with any fair degree of success.

3. Once the upper respiratory tract becomes diseased it is important to determine whether the infection originated in the tract itself or is a manifestation of some cryptogenetic involvement.

4. It is likewise essential to ascertain whether the infection is primary, or an exacerbation of a latent infectious state of one or more of the paranasal sinuses.

5. The general management of acute upper respiratory tract infections, although empiric and uncertain in its effects, is more important than any topical treatment to the nasal cavities.

6. The local therapy involves nasal medication on a physiologic basis and is more certain in its ultimate effects.

7. Newer advances in local nasal therapy embrace primarily postural methods of nasal medication.

8. In acute sinusitis as in acute rhinitis measures to increase the general resistance of the patient are of paramount importance.

9. In subacute sinusitis mechanical cleansing of the nose and sinuses by some form of lavage is in order, but a warning is heralded against its persistent use since it frequently interferes with the normal healing process.

10. Recent studies have convinced me that the membranes in most chronically infected sinus cavities are not irreparably "diseased" as usually interpreted, but possess the faculty of repair, and therefore should be labeled "reparative" or "resisting" membranes. These membranes should not be extirpated.

11. Finally, in the light of present knowledge, the prognosis of upper respiratory tract infections could be made more encouraging by following the newer trends toward conservatism.

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GROWING CHILDREN — OUR RESPONSIBILITY*

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To be invited to address such a learned audience as this arouses in me two emotions: pleasure that the privilege should be accorded me, and fear lest I have nothing to offer suitable for the occasion. Custom and precedent make it possible for me to develop this address either from the strictly scientific side or from the more philosophic point of view. For me to attempt a scientific presentation would be a bit of intellectual impudence. Filled as I am with hesitancy and misgiving, I think it well at times for us to draw back a little from the details of immediate and practical projects and view in broad perspective our medical and social problems, our trends, directions and possible needs for readjustments.

It has always seemed to me that the greatest difficulty in the practice of medicine is to maintain the right balance between scientific and practical, or social medicine. Scientific medicine in America today is the envy of the rest of the world while social medicine in America still leaves much to be desired.

In taking a critical view of our system of medical practice today we are most certainly doing nothing new, but all too often it leads to nothing more than the negative result of skepticism. Any change in any one of our social institutions today rapidly produces change in all other parts of our delicately integrated social structure. Medicine does not stand alone; as physicians we are an integral part of society; we must change as society changes. Our present need is not to fear change but rather to assume an intelligent leadership for the changes that must necessarily affect our future.

History will record results not shows. As Americans we need to be humble about the question of intellectual leadership. It is interesting to note that of the six Nobel prizes awarded in science in the year 1939, five went to Europe and one to America.

In the whole history of American medicine there has never existed a greater need for healthy bodies and sound minds, nor has there been a time when physicians should be as vitally interested in the perfection of plans which will supply better and more evenly distributed medical service for all people as now.

With the introduction of the exact sciences into medicine during the last century, medical research has given to man some of the most helpful knowledge that the human race has ever acquired. The science of medicine has attained an enviable position; the practice of medicine, which is an art and can never be an exact science, has been made to assume a secondary rôle. New trends in the practice of medicine are clearly indicated but with the rapid advancement of scientific research the art of medical practice seems to have fallen

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into a state of complete inertia. The judgment of the physician, which more and more determines the difference between a mere doctor and a good doctor, has been assumed by laboratory medicine.

Dr. Howard W. Haggard of Yale University School of Medicine says: "The practicing physician is not a scientist. He is, if he really practices medicine, more, far more, than a scientist. He is a scientific artist. He does not deal with the controlled and limited matters of the laboratory; he deals with human beings. So long as the human mind in its full ramifications remains beyond an evaluation with scientific precision, then the practice of medicine must remain an art. So long as medical practice involves the personal contact of physician and patient, then it is the art of the physician which must establish the necessary bond. This is very different from medical research. It is, in many ways, more difficult. It involves not only intelligence and skill but also qualities of personality unnecessary to the research worker.

SCIENCE AND MEDICINE

"In the first flush of the triumphs of the application of science to medicine, it appeared that all the problems of medicine were to be answered and that medicine at last was destined to become as exact and impersonal as engineering. In consequence, to the eventual great detriment of the practice of medicine, our medical education was changed. It adopted the precise methods of science. It built its structure on the laboratory as a foundation."

We all recall the time when the diagnosis depended on the intelligent interpretation of the history and findings on careful physical examination. Today the tendency in our medical schools is to emphasize the importance of laboratory procedures and to minimize the importance of a detailed history and a thorough physical examination. What is the result? We have a generation of physicians growing up who trust implicitly in the findings of the laboratory and are almost helpless without such data. This generation does not realize that just as many mistakes are made in the laboratory as in the sickroom; and that in practice the doctor must, in most instances, make his diagnoses and treat his patients without the aid of a laboratory.

The time was when the preeminence of such institutions as Johns Hopkins was based on its famous clinicians. Today a medical school is judged on how well it trains its students for research rather than how well it trains doctors to practice medicine. Today many of our better medical schools are manned by Doctors of Philosophy rather than by Doctors of Medicine—certainly in the preclinical subjects. Science and the laboratory are being stressed even in the premedical field in the colleges of arts and sciences. It may be said that medical training is being divorced from medical practice.

PUBLIC SPIRITED PHYSICIAN

Throughout the whole period of medical practice there has never existed a greater need for the socially minded, public spirited physician than exists today. Too many of us insist that all medical gatherings be for the purpose of discussing exsection of gallbladders, rib resections, intravenous therapy, etc. It might be in order to suggest that there is something in the minds of medical men extraneous to all these, that they have not valued—perhaps not even suspected! We forget that public opinion must determine the condition and future of medicine. It is not what medicine does that holds the physician in high public regard; it is what the public thinks and believes. The social worker and the politician of today know that the greatest, possibly the only, field of social betterment is the field of medicine and health. Many aggressive lay groups stand ready to raid the medical field for its unapplied social potentialities. They assume that there is something basically wrong with the present form of medical practice. Their first inclination is to remake the plan of medicine. Eric Johnston, president of the U. S. Chamber of Commerce, says: "We know free enterprise can work. It's up to us to see that it does." American

medicine is free enterprise and it's up to us to see that it works!

The present global war, with its far flung battlefronts, has created many new and unexpected problems and has placed heavy demands on the medical resources of our country. Our present mode of living, thinking and acting has been challenged; our weaknesses have been exposed to ridicule, while our scientific progress in the control of infectious diseases, including the almost complete eradication of a few by prophylactic inoculation, has been little short of miraculous. However, other diseases, such as rheumatic fever, cancer and tuberculosis, have begun to assume leading rôles in the medical scene.

CLAMOR FOR SOCIALIZATION

The clamor for socialization by groups within and without the profession prompts me to remind you that the public gets what it wants. Public demands must be met regardless of the cost to the taxpayer. The moment any lagging is noted in our program for adequate medical care, the enthusiasts, both within and without the profession, put up the cry for the creation of a department of health in Washington. In other words, too many of us elect to follow the lines of least resistance. I would remind you that any concentration of power breeds disaster. The problems of health of West Virginians should be the personal business of West Virginians to solve within the confines of our own State. The history of all democracies is that of disintegration. As physicians today it might be suggested that we are contributing our full measure of such disintegration. The broad outline of the challenge is clear. There are ramifications in economics, social security, education, sanitation, public health and a score of other fields. Specialization has been carried so far in recent years that it has caused a perverted view of life in many minds.

It is the lot of statesmen to draw the master plan but the details belong to professional and intellectual groups in every walk of life. The medical problem embraces a wider horizon than routine calls to the homes of the sick, or the meticulous technic displayed in the operating room. Shall our profession be so organized and so constituted that its members will continue seeking to expand their work in the field of preventive medicine? Through national, state and municipal organizations can they be kept informed of relevant scientific discoveries and brought to comprehend their significance from the standpoint of application to the child? Having comprehended, is it too much to hope that our profession will overcome inertia, not only in accepting an obligation for detailed work but also in creating within itself the means of leadership so that coordinated opinions and experience can be utilized when the enterprise requires cooperation with industry, education, government and other agencies outside the medical profession?

Some startling situations already have been revealed by physical examination of the young men of the nation under the Selective Service Act. From the assembled data not only can we specify the points where preventive medicine has failed. We can do more. We can prove by tangible evidence contained in the data that many disqualifying physical defects had their origin in the years of childhood.

PERCENTAGE OF DEFECTS

Of the first 3 million men examined for general military service 900,000 could not qualify for even limited service. This means that about 30 per cent of the young adult male population of the nation suffered from major defects. Although standards have since been altered so that some of those rejected are finding a place for service, it is no credit to the science of preventive medicine that the demand for manpower should have necessitated changing the standards.

While the physical requirements for military service are more exacting than those required in most civilian activities, the prevalence of physical defects among this cross section of the young adult male population has serious implications for individual and social security. It is of little use to argue

whether preventable disease and deformities are more often the cause or the result of poverty; in either instance it is necessary that all segments of the population get whatever medical care they need to put an end to demoralization and dependency.

DENTAL CARIES

Dental caries is certainly not exclusively a medical problem but just as certainly the physician is not justified in unloading all of the responsibility for its correction and prevention on the dentist. At present, the only way of controlling the spread of caries consists of periodic visits to the dentist, beginning at the age of two or three years and continuing throughout life. Many families are unable to meet the cost of regular dental supervision. For them there is definite need of subsidized care.

There is no longer room to doubt that the tendency of teeth to decay is affected by nutritional factors. Authorities are not agreed, however, on the relative prophylactic importance of the different dietary essentials. Although research in this direction needs to be continued, the need for more work does not remove the responsibility of giving the child the chance to benefit from all that is now known of the completely balanced diet. The conclusions of such an observer as Boyd of Iowa argue strongly that such diets can arrest the progress of caries. Children subject to rigid control of diet because of diabetes exhibited a greatly lowered caries rate in comparison with children whose diets were not so carefully supervised. The application of this knowledge in daily practice is not easy. The eating habits of the seemingly healthy child cannot be regarded as something requiring rigid medical discipline. Parental strain and normal childhood rebellion against such a course would soon lead to emotional disturbances in the home too great to justify a discipline that is accepted willingly when a known disease has furnished the cause.

Fortunately, another way is open—a way which is too seldom used. I refer to the dietetic analysis of carefully prepared records of what the normally and wisely disciplined child is choosing to eat in the home, while at school, or at the corner soda fountain. Data are now accessible which make it possible to appraise the analysis from the standpoint of most of the known food essentials. The appraisal becomes the basis for advice on substitutes and alterations which allow the child a maximum of freedom with respect to choice of foods.

I mention nutrition first among the systemic factors affecting the incidence of caries because a wisely selected diet has much more to commend it from the health standpoint than merely the prevention of caries. The time may be near, however, when definite progress in the fight against tooth decay will be made by the relatively simple procedure of adding flourides to our drinking water.

RHEUMATIC FEVER

The results of examination of the young men of America under the Selective Service Act indicate that 4.8 per cent are disqualified because of cardiovascular diseases. Rheumatic fever as an etiologic entity in this group is by far the most important. Rheumatic fever, according to the Bureau of the Census reports, is responsible for more deaths of children from five to fourteen years of age than any other cause, and accounts for a large number of deaths in older age groups as well. All of you are familiar with the story: the tendency to recur over a period of many years, each attack meaning many months of bed care. The fatality rate is approximately 20 per cent. This disease presents a challenge to all of us who are interested in preventive medicine.

JUVENILE DELINQUENCY

The conduct of the child is simply a reaction to environment. It is the result of a struggle between instinctive strivings and the limitations and inhibitions set up by environment.

The prevention and correction of juvenile delinquency presents one of the biggest social problems of our time. Does the child come

out of an inadequate home life into delinquency? The family life that we have known over the years is at this time undergoing a process of disintegration, and many of its responsibilities and obligations are now being delegated to nursery schools, kindergartens, summer camps, tutors, and nurses. An ever increasing number of parents are beginning to assume that, like the family washing, the educational and moral welfare of the child can be more economically and efficiently cared for outside the home. This attitude toward parental responsibilities is the cause of much of the criticism that is directed toward the younger generation today.

In spite of all the present day criticism of the home and of parents, the fact remains that both should continue to be the dominating factors about which the physical, mental, and moral welfare of the child must necessarily develop.

CHILDREN IN NEED

Since the turn of the century, parenthood, the home, the church, and education, all have been subject to question. The scientific attitude may be said to have taken the place of conviction in child rearing. We are living in a world that threatens to brush aside everything that intelligence stands for, most of the population of the earth waging war and destruction; confusion over issues and values that leaves most humans frustrated and uncertain. Is it little wonder then that the temptation is to forsake reason and resort to force?

If a boy is aggressive toward other boys or persistently steals in school, one can turn to punishment to "knock it out of him," or, one can look for the cause underlying his behavior. In order to understand the conduct of any human being, child or adult, whether he be found in the home or the prison, the conduct must be interpreted in terms of the individual's total experience, training and education. In treating delinquent children, we are not limited to physical force or to "appealing to the child's better nature." We have known for many years that there is no single approach to understanding a child, and with complex cases we should see to it that a fourfold investigation is made: the physical, the psychological, the social and the psychiatric. It is the responsibility of physicians to see to it that in our school system these diagnostic facilities are available and that resources for carrying out the treatment are adequate.

I am sure we all agree that delinquency centers in the home. It is going to be necessary for us to turn to investigation of the homes from which we know are coming increases in delinquencies. Also, we must determine if such children are gathered into overcrowded schools, especially those schools lacking the organization and personnel to deal with the child as a whole. We shall have to pay for better schooling. Are recreation facilities necessary? Are they adequate? Are courts, welfare agencies, and clinics insufficiently staffed? These are the real roots of delinquency.

Our sentimental appeal to the "better nature" of children is but a bit of realism. Physical punishment is but a return to barbarism. The accomplishment of results rests with the parents, the schools, the churches and the public and private community sources. All of these agencies develop the child. When any one of these fails, the others must make up the deficiency. Where children are in economic need let us be honest in admitting the need rather than emphatic in our demand for physical discipline.

WHAT OF TOMORROW?

Who will finally construct this nation's philosophy, may I ask? It is not the doctor, not the teacher; it is the children who will live it out, children from all stations in life, many in underprivileged areas, who will relive and remake the philosophy of our land. Force makes only for regimented lives. The Germans and the Japanese are examples of regimentation of human lives without a decent respect for the rights of others.

Behavior must be studied as we study health or engineering. We spend almost

thirteen times as much money to control crime as we spend for education. The reverse should be true. If we would put as much thought, prayer, effort and money into behavior problems and the working out of preventives of crime as we put into physical health measures, juvenile delinquency would not be the challenge to the stability of our society that it is today. The rapidly increasing incidence of juvenile delinquency constitutes a definite challenge which should stimulate us to a better and wider application of our increased knowledge in this field.

RACE SUICIDE

It is within the province and power of parents to shape the destiny of tomorrow's world—and that's the biggest job of all time.

The almost universal use of contraceptives today is rapidly bringing about a condition of "race suicide." The more civilized and the higher the education in any race, the greater becomes the demand for contraceptive measures.

Far too many married couples today feel that in becoming parents they will miss the enjoyment of a full social life and so they spare no effort in refuting nature in her noble purpose of creating man. The less favored financially are forced to abide by the natural consequences of their poverty, thus permitting nature to have full sway in the rôle of gestation because of their inability to purchase the necessities for obviating the fulfillment of the God-given command to multiply and replenish the earth.

It was Da Costa who said: "The blatant and militant suffragette is well along on the highway of degeneration." In recent years woman has elected to compete with man in the business and professional world while the home takes care of itself. I am one of those who feel that the woman who works as a man must put aside womanly things in general. When woman invades man's callings she must put aside healthy babies, the home and the successful rearing of children. When woman quits the home she wrecks the chief hope of our civilization. The real profession of woman is matrimony; the delivery of her progeny, and the making of a clean, decent, happy home. To make a success of this will require all her ability and energy, her tact and self-sacrifice.

History teaches us that a vigorous nation usually has a high birth rate. In America there has been a steady decline in the birth rate, beginning in the early 1920's. The acceleration of youthful marriages in 1942 and 1943, which war always brings, has temporarily arrested this decline. I believe that we can assume that the downward trend in birth rate will reassert itself after the return of more normal times. Sooner or later we in America will be forced to come to grips with this problem.

Many competent observers of this vital situation seek the remedy through a change in our sense of values. Artificial social standards tend to cause children to be regarded as an economic handicap. A more mature, real sense of values would cause us to welcome children as a joy and accept the "sacrifices" which go with them.

Because of artificial social standards the families who should have four or six children now have one and, at most, two children; while in the so-called "relief" group we find four and more children. This adds up to "race suicide." Yet society takes almost no account of this condition. Too many physicians are contributing to this procedure today.

MATERNAL AND INFANT DEATH RATE

We have a low maternal death rate, but in spite of it more than 13,000 American families are deprived every year of the wife and mother. More than half of these tragedies should be prevented. Our low infant death rate means that about 70,000 babies die during the first month of life, and approximately 75,000 infants are stillborn; in other words, in any year competent observers tell us that 144,000 young women go through the trying period of pregnancy and childbirth, and their reward is a dead baby or one that will die within a few weeks.

Medical science has taken the pain out of

childbirth today and made it unnecessary for the mother to suckle her baby at the breast. The tragedy in this scientific progress lies in the lessening of responsibility toward their progeny which only too many mothers appear to welcome.

The necessity for increased cost of medical and hospital care has probably contributed, in a small way, to our problem of race suicide, and this in spite of the fact that we still consider the home a safe place in which to have a baby. Environmental immunity found there affords a wide margin of safety for both mother and baby.

TUBERCULOSIS

Many years ago Sir William Osler said to the general practitioner: "The leadership of the battle against the scourge of tuberculosis is in your hands. Much has been done, much remains to be done. By early diagnosis and prompt systematic treatment of individual cases, by striving in every possible way to improve the social condition of the poor, by joining actively in the work of the local and national antituberculosis societies you can help in the most important and the most hopeful campaign ever undertaken by the profession." This statement was a challenge to the medical practitioners at that time but it is a greater challenge today. Have we heeded the advice of the master physician? The answer would appear to be definitely in the negative when we are told by observers that there are in the United States about two hundred deaths daily from tuberculosis. Despite the facilities available at this time for diagnosis and treatment of this disease, between 80 and 90 per cent of such cases are in the moderately advanced or advanced stage when treatment is first begun. Why should such a situation exist? The explanation, in part, is that tuberculosis is not dramatic and presents almost no signs or debilitating symptoms in the early stages.

It is my belief that tuberculin testing, preferably by the family doctor, should be done at practically all age periods. This might sound startling, but the reason is just this: People cannot be impressed concerning tuberculosis unless they can see and feel something. Doctors will not take responsibility unless they have something definite that they can do and charge for when they can get the money. If we all do routine tuberculin testing it will have the same educational value that has resulted from the routine immunization procedures. With the child such procedure will impress upon parents the value of checking servants and others employed in the homes. It will do more. It will carry into the schools the demand that teachers and all school employees be free from infection. I mention this because about all we are doing today is trying to stimulate interest among those people in whose families tuberculosis has already struck. We are doing very little preventive work.

Dr. Lawrason Brown reminds us that "the most important factor in diagnosis in the majority of cases of pulmonary tuberculosis is keeping the disease in mind."

Turning now from our responsibility for the physical growth and protection of the child, we have an equally challenging responsibility—that of the mental health of the growing child. This necessarily involves the home, the type of school and school life to which the child is exposed. This leads up to a point of view which I have steadily maintained since I was graduated from medical school. I believe that the practice of medicine is essentially an educational job, and, moreover, I believe that every physician is potentially an educator in the true sense of the word, and as such should have adequate training for the job.

Mental health—the importance of personality growth and development in the educational life of the child calls loudly for a closer cooperation between physicians and educators. The responsibility for the development of desirable habits, and the preservation of the child's mental health constitute a mandate that parents, physicians, and teachers equip themselves with the knowledge which is so essential in order to understand the motives which govern conduct.

The phrase "adjustment of the child to the school" sounds bad to physicians who are interested in the mental health of children. We prefer to talk about "adjusting the school to the child."

Education consists in systematic preparation of young individuals for the work of life, the chief concern being to fit the child to make a living rather than to prepare him for the art of living, a system of subject-matter learning, mass learning, carried out on a mass basis. With a minimum of friction the attempt is made to fit each child as a cog in the wheel of modern civilization. If the child fits into the wheel, the result, according to our present standards, is a so-called successful man or woman. If the child rebels on the premise of being an individual there is likely to be failure and disaster, again as viewed by our present standards. Material success is seldom the basis upon which happiness is erected. Peace and contentment have no such origin. Joy and gladness are experienced only by those who live on terms of approval with their consciences and in tune with their better emotions.

SCHOOL ENVIRONMENT

My observation is that because educators have thought so long in terms of subjects to be mastered and the carrying to completion on scheduled time a specified program for large groups of children, it is impossible to give attention to the development of personalities. Any teacher who goes on the assumption that books are more important than girls and boys is in need of a change of vocation.

Up to the present little consideration has been given to the matter of training of individuals for parenthood. The number of agencies for child guidance is steadily increasing. The reverse should be true.

Hundreds of our children are attending school in places—designated as school rooms—that are a disgrace to the state of West Virginia. The child, at the age of six years, is snatched from its mother's arms and planted on a hard seat, there to remain for five or six hours daily, encompassed about by four walls of unattractiveness. We widen our highways so that fools and drunks will not kill themselves or others. We span the streams with marvelous bridges to prevent congestion in travel. But our schools continue to be overcrowded, unscientifically lighted, inadequately heated and poorly ventilated. The toilet facilities of the average primary school building in West Virginia today are nauseating.

It is in just such environment that the child of six years is started on the broad highway of education—being conditioned for life's work.

DISCIPLINE THROUGH FEAR

Conduct is thought and feeling displayed through bodily activity. Conduct motivated by fear bespeaks an inadequate, unhappy child. Yet the instillation of fear is the chief disciplinary agent in the school, as well as in the home. Fear is not a normal, natural emotion. To make a child afraid is to rob him of happiness, spontaneity, and the will to exercise those innate forces which make for good.

We need many more teachers competent to advise on problems involving the emotional growth and personality development of the child. This need extends also into the nursing and medical professions.

Each child that enters the classrooms of our schools, or the offices of our physicians, presents an individual problem. In some 30 million separate and distinct problems is the raw material from which our America of tomorrow will be produced. The number of peculiar, eccentric, maladjusted individuals, the psychoneurotics, as well as the criminals, coming out of this mass of raw material, will be determined largely by the procedure which parents, teachers, physicians, and the church utilize for making a healthy, happy childhood. The methods employed thus far have been haphazard at best.

I have already said that we shall have to pay for better schooling. John Dewey said: "What the most intelligent parent desires for his own child, that must the community desire for all its children." Failing in this

we shall have to pay much more to control crime.

One of man's most priceless possessions is the memory of a happy childhood. An unhappy child is made so by some adult. Given my way, our children would not be inducted into school until they have attained the age of eight, or better still ten. The first steps in education should be organized schedules for play in the fields and forests and along the banks of streams, to view God's hills and the beauty in the flowers and trees. Education begun in such a wholesome atmosphere would stimulate intellectual curiosity, and also, in this environment would we learn religion. The Great Architect has ordered it so.

The way in which our children utilize the knowledge acquired during their formative years will determine their response to the problems of tomorrow. Most of us here assembled still cling to the moral and religious principles held out to us as children by our McGuffey readers. Observers tell us today that less than 5 per cent of school textbooks have any religious emphasis. The contemplation of a well fed mind in a malnourished body with a starved soul stimulates me to ask: "What price the modern streamlined education today?"

If I read the signs properly educators are about to be rebaptized in simplicity as the cornerstone in education. The three R's and spelling will save us from barbarism and chaos.

The National Education Association reports that the average yearly salary for teachers in the United States is $1,550. I am told that this figure is higher than the average salary paid to the teacher in West Virginia. The 1943 session of the legislature granted an annual bonus of $25.00 to each teacher for the years 1943, 1944 and 1945.

Since our teachers are paid for nine months' service they have the good fortune of being available for gainful employment during the summer months. In this way most of them can earn enough money to carry them through the months that they are on relief wage.

It is certainly not to the credit of our state that its teachers have to maintain a powerful political lobby in order to stimulate laymen to interest themselves in the problems which educators have to face in the present program to maintain perspective. The teaching profession should be economically independent, adequately paid and beyond the clutches of the politician. In the end, it is the child who pays the price for poor teaching.

An ever growing chorus of critics, both within and without the academic circle, is demanding with increasing insistence, that a thorough revaluation of educational procedures be made.

CORRELATION OF MEDICINE AND EDUCATION

The total personality of the child is the mutual concern of educators and physicians. In some measure it is going to be necessary to correlate the activities of teachers and the group of physicians interested in keeping normal children normal.

As physicians we need to know a great deal more of the problems confronting teachers in our elementary schools. And, with profound humility, I dare to suggest that our educators might be helped by knowing a few things which we as physicians have learned from long years of dealing with children. As physicians and teachers we are practicing democracy. Our way of life has an impact on our professions today calling loudly upon us to create in the homes, the schools, and the churches in every community the kind of environment which will help individual children to make the greatest contribution to our social structure as a whole. To do this is democracy, is good teaching, and also good practice of medicine.

I pose the question: "Have we trained the school physician in the best way?" Or is it that the school physician, like the public health physician, comes and goes with each change of the administration? I believe that the school physician of today is relatively uneducated as far as his knowledge of the relation of emotional, social, and economic factors to disease states goes. Disease and

health, whether physical or mental, whether public or private, whether the former is curative or preventive, are now problems of concern to all people. Health education in the schools is the crying need today. The career of "school medicine" should be as stimulating as that of bedside practice or the dramatic glamour of the operating room.

SUMMARY

In presenting some aspects of our responsibility to the growing child I have rambled from our system of medical education, far afield across the domains of the home, the church, the school, and finally to our fitness for the rôle of adequately trained clinicians, with wide interests, who understand growing human beings and can act wisely for all the multiple aspects in the making of a healthy, happy child. Any physician becomes inefficient and nonprogressive unless he is inspired by imagination and the curiosity to learn. It is important, therefore, that he should appreciate the spirit and understand the principles of research, and also develop an investigative habit of mind. The growing, ever changing child presents the constant inspiration.

Since medicine deals so essentially in human problems, the good physician must constantly strive to broaden his outlook on life; and he may do this by cultivating interests that may appear extracurricular to the practice of medicine. This will embrace a concept of greater good to be accomplished through leadership and cooperation with all human agencies concerned with the rearing of healthier and happier children—to work with, not to oppose, those leaders in other fields which exist to prepare the child for the responsibilities of citizenship and to protect him from exposures which can undermine his physical health.

It was Mr. Justice Holmes who said: "I believe that the wholesale social regeneration which so many now seem to expect, if it can be helped by conscious coordinated human effort, can be effected appreciably only by taking in hand life and trying to build a race."

In the clouds that hang rather thickly upon the whole horizon of the institution of medicine the healthy child presents a radiantly bright spot. Whatever be the confusion of today or the uncertainty of tomorrow, if we would have a free America we must work together.

It is my wish to leave with you the words of Albert Pike, who said: "What we have done for ourselves dies with us, what we have done for others and the world remains and is immortal."

SALERNO

The place that figures so prominently in the news of today played a significant part in the history of medicine. The School of Salerno flourished from the beginning of the ninth to the end of the fourteenth century. Like Montpellier in the beginning, Salerno was purely a medical school. Its origin is veiled in mystery. In the fourteenth century it was overshadowed by Montpellier and Bologna and was finally put out of existence by Napoleon. In its heyday it attracted students from all over the world so that it merited its medieval name, Civitas Hippocratica. It is noteworthy on six counts: 1. As the place where lay medicine emerged from ecclesiastic domination; 2. It was at Salerno that decadent Greek medicine was rejuvenated by Arabian learning; 3. The first medical-practice act in the western world (Persia may have anticipated Salerno) was enacted at Salerno. 4. The home of Roger of Parma, the Surgeon; 5. Trotula; and, 6. The Regimen Sanitatis Salernitanum.—*J. Kansas Med. Soc.*

STOMACH CANCER MORTALITY HEAVY

Approximately one-third of malignant tumors are located within the stomach. There are more deaths from cancer of the stomach than from all malignant tumors of the lip, tongue, cheek, tonsil, pharynx, larynx, salivary glands, thyroid, male and female breast ovary, uterine cervix and corpus uteri combined. One realizes, therefore, that the "cancer problem" cannot be solved unless cancer of the stomach can be satisfactorily controlled.—*Isabel M. Scharnagel, M. D., in Medical Woman's Journal.*

Deletion of nearly a third of the drugs in the National Formulary and acceptance of about 115 new monographs were approved by the Committee on National Formulary.

THE DOCTOR-HOSPITAL PARTNERSHIP IN PUBLIC RELATIONS

By
C. F. RUNYON
Manager, Charleston General Hospital
Charleston, West Virginia
and
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Huntington, West Virginia

THE doctor-hospital relationship entails mutual understanding and harmony, if our clients, the patients, are to be given the best of service. This relation must be maintained at all times on the same basis as that of doctor and nurse, which has been recognized for years. Although the doctor must, through a sense of dignity and responsibility, maintain a certain amount of reserve with respect to hospital employees, it is essential that he and the hospital, as exemplified through management, work together in all things for the betterment of the hospital, since one is dependent upon the other. Interdependability manifests itself in this particular enterprise more than in any other field of endeavor.

The physician and the hospital authorities must meet the public, aware of their duty of rendering efficient and up-to-date service. If this service is not rendered at a reasonable cost through groups and private enterprise, then we can expect the government to step in and do it for us. The ever increasing trend along socialistic lines makes it imperative that we keep a firm hand on the reins to stave off this political domination.

After we have made accessible to the public a quality of hospital care based on service, the next step is education of the laity through a sound public relations program.

If this program is to be sound, the first and foremost point to be emphasized is the service aspect, just as in such allied fields as medicine and dentistry.

The service offered must be of the highest possible type, and must be rendered with cheerfulness by all of the employees of the hospital who come in contact with the public in any manner. It not only has to do with the service actually rendered the bed patient in the course of administering medications and performing other professional services, but must include in its scope additional service to the patient from all departments, from admission to discharge, continuing later through the social service.

When a prospective patient or his agent is greeted at the front office it should be with a spirit of helpfulness since we are dealing with an individual who is suffering from an emotional strain incident to illness. It has been reliably said that 90 per cent of the people are honest, so let us forget, for the moment, the monetary consideration, important as it is, and devote this time to alleviating apprehension. After the patient has been made comfortable and has been assured of the hospital's desire and willingness to be of service, financial arrangements may be discussed.

The departments such as dietetics and pharmacy have the responsibility of seeing that the physician's orders are carried out to the letter as regards special diets, prescriptions, and the like. In fact, every department has its peculiar function, and must do its part, but it is the nursing service which has the opportunity to be of greatest help, since for twenty-four hours each day the nurses are caring for the patient.

Before leaving the part which service plays in a well rounded public relations program, it might be well to mention the part that rates when wrongly quoted or not fully explained to the patient, can play in tearing down good will, regardless of how valuable the rest of the program might be. Hospital administrators would do well to follow the example

of insurance companies or the Blue Cross non-profit organization in making actuarial studies and arriving at figures which should, when quoted to patients, be all-inclusive. Patients are greatly upset by the extra charges that are made. Probably as much study and work need to be done along these lines as along any other that confronts the hospital today.

The term "public relations" has been defined as "relations with the public" including all of the populace within a given locality. This relationship is best begun in the doctor's office before the patient is advised to seek hospitalization. The hospital can be helped greatly if the doctor will only take a few minutes of his time to explain to the patient the basis for various hospital charges, which are a necessity if good service is to be dispensed. The hospital, like any other type of business, has monthly bills to be met, and other obligations to fulfill.

There are several requisites if the most efficient service is to be rendered, and these can be briefly summarized as follows: (1) a competent staff of physicians, trained to do the most expert work in their respective fields, (2) a modern nursing staff which of necessity must be under the direction of competent instructors, (3) a business administration which should be in charge of a trained hospital executive, and (4) adequate records which in turn should be a stimulus to the entire hospital personnel.

USE OF PENICILLIN IN WAR WOUNDS

The British Medical Journal and Lancet report on the use of penicillin in the Sicily and North Africa theatres of war. Physicians are enthusiastic about results in war wounds for prevention or control of infection with pyogenic cocci. Surgeons can now suture gunshot wounds without fear of spread of infection to the blood stream and there is saving of life, limb, fighting-man hours, dressings, hospital service, equipment and transportation. Wounds treated with penicillin healed from three to six weeks faster.—*R. N.*

Tuberculosis Abstracts

Furnished Through the Courtesy of
The West Virginia Tuberculosis Association

No situation confronting the medical man demands more discriminating judgment than the management of tuberculosis when complicated by pregnancy. To terminate the pregnancy, to institute collapse therapy, or to adopt a policy of watchful waiting must be decided in the light of all factors, pathological, physiological and emotional. In the weighing of these factors, the experience of men who have made a special study of such cases is valuable.

Pregnancy in Advanced Tuberculosis

The clinical onset of tuberculosis in many women is associated with pregnancy. Since collapse therapy has improved the chances of the tuberculous patient in general, re-evaluation of the effects of pregnancy upon the disease was undertaken. A selected group of 26 patients with tuberculosis, treated with various types of surgery was observed before or during pregnancy. The average period of clinical and roentgenologic observation was 9 years, during which 40 children were born of whom 36 were alive and well. Nine other pregnancies terminated prematurely. Tuberculosis was confined to one lung in 15 patients. In 11 it occurred in both lungs. Of the 26 cases with an effective collapse, only four showed an unsatisfactory course during pregnancy or following childbirth and of these, three later improved, the fourth had a spontaneous abortion. In three patients in whom collapse therapy was not satisfactory, there was a reactivation following childbirth.

In patients in whom the diseased areas of the lung are anatomically well collapsed, tuberculosis will not become active in pregnancy. Phrenic nerve interruption alone is inadequate. Physiologic, social and pathologic factors should be considered before determining the hazard of pregnancy but the safest interval for a tuberculous woman to have children is during the period of effective collapse therapy.

The Harmful Influence of Pregnancy on Advanced Tuberculosis as Modified by Collapse Therapy, J. W. Cutler, M. D., Amer. Jour. of Obstetrics and Gynecology, January 19, 1944.

Continued on page xxvii

The President's Page

For the past two weeks many of my friends, both in and out of the profession, have sent me clippings from the New York Times of June 4, 1944, the headline of which reads as follows: "Kickback Racket Brings Penalties for 272 Doctors". This in so many words is the old bug-a-boo of fee splitting under a new name. To say that we have not had this problem for some time would be a gross exaggeration. However, it should be pointed out that the College of Surgeons, as well as other organizations within our group, has done its level best to stamp out this evil practice.

The practice of medicine has been and will continue to be a noble profession. But, when some of its members stoop to underhanded irregularities in the collection of fees, then something is definitely "rotten in Denmark".

The practice of medicine has become big business. It is expected that every practitioner will submit a just bill for services rendered, the fee depending somewhat on the individual's ability to pay. There is nothing to be ashamed of in the rendition of an honest bill. There is much to be ashamed of, if the bill is excessive, and out of all proportion to the services rendered . Likewise it is atrociously disgraceful and dishonest for any member in our profession, or any other profession, or any business man, to receive a fee that has come to him in some silent, roundabout, underhanded way, at the expense of an unsuspecting public.

It is stated in this newspaper article that 2,697 physicians in New York City alone have received extra remuneration in the form of "kickbacks" from 1941 to December, 1943. The heat so far has been put only on physicians of Brooklyn, but apparently more heat is to follow. Again let it be noted that the disciplinary action was based on recommendations of the Compensation Board of the Medical Society of Kings County. So in Brooklyn it was the medical society that brought the facts out in the open and recommended the verdict.

Now, let's get away from New York and Brooklyn. Let us come back across the magnificent Alleghanies to good old West Virginia. Are we better than our eastern brethren? Do we remember the words from the Good Book, "Let him who is without sin cast the first stone"? Frankly, I don't know whether we have a similar problem in West Virginia or not. To be sure many of us frequently hear rumors of fee splitting in our midst, and more recently I have heard rumors of "kickbacks". They are only rumors. I personally have no facts. But let me say to you members, yes all members of our profession, including myself and every other member of the healing art, fee splitting in any form is a rotten, dishonest, disgraceful act. And I say to you individuals who may occasionally stoop to this vicious practice, "cut it out".

To you County Societies, let me urge an immediate and thorough investigation to see if there are irregular practices within your groups. If found, let them be cleaned up as quickly and as quietly as possible. No, boys, I'm not preaching or singing the gospel. I'm not accusing anyone of misbehaving, nor am I claiming that there is anything "rotten in West Virginia". I'm merely saying, if there is, "let's have done with it".

President.

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A "MUST" DATE FOR JULY

The opportunity to observe the methods of modern treatment of wounds and diseases at an Army hospital is being offered the doctors of West Virginia in connection with the annual conference of the Sixth Councillor District, July 15-16, at Ashford General Hospital, White Sulphur Springs. What was originally scheduled as a district meeting now has developed into a state wide affair. So much interest has been manifested in the meeting, that Colonel Clyde M. Beck, Commanding Officer, has, through the Councillors for the Sixth District, extended a general invitation to the doctors of West Virginia to attend the sessions.

We have all heard of the excellent work being done at Ashford, and we feel sure that all West Virginia doctors who can possibly do so will accept the invitation to visit the hospital as guests of Colonel Beck and his staff.

The scientific program which will be presented Saturday evening, June 16, will be of interest to doctors generally, and many will undoubtedly be in attendance at ward rounds and clinics arranged for Saturday afternoon and Sunday morning.

The social angle should not be lost sight of, and those who have been members of the State Medical Association for the past several years will welcome the opportunity afforded to use again the full facilities at this one-time world famous resort where so many of our annual meetings have been held.

CRISIS IN MEDICAL EDUCATION

At a time when the whole world is confronted with a need for well trained physicians as never before, American officialdom is apparently willing to cut off the supply at its very source by refusing to permit premedical and predental students to be placed on inactive status in the enlisted reserve corps so they may continue their studies, *The Journal of the American Medical Association* for June 10 declares in an editorial demanding that the problem be taken, if necessary, directly to Congress and to the President. *The Journal* says:

"Under Medicine and the War in this issue of *The Journal* appears an official statement by the Directing Board of the Procurement and Assignment Service relative to the present status of the effort to secure a continuous supply of physicians The condition seems to have reached a stalemate. Apparently the responsibility for action lies now with the Director of the Selective Service System, General Hershey. Several high officials of our government have indicated their complete sympathy with the necessity for maintaining continuity of medical education on a high standard. Apparently, however, the Secretary of War, Henry L. Stimson, and the Secretary of the Navy, James Forrestal, are not sympathetic to this need. They have said in a joint communication that the proposal to place premedical and predental students on an inactive status in the enlisted reserve corps so that they may continue their studies would provide immunity from military service for five or more years to a selected group of young men. They suggest, moreover, that the essential in the selection would be the ability of the parents to finance the education, together with the ability of the student to complete

the premedical or predental courses and thereafter to qualify for entrance into approved medical or dental colleges.

"Apparently the Secretary of War and the Secretary of the Navy oppose granting deferment to premedical students, notwithstanding the fact that it will lower tremendously the number of graduates in medicine and dentistry in the years 1948 and 1949, on the grounds that the armed forces need young men of intelligence with the proper physical qualifications and that the immediate needs of the war for their services ought not to yield to the prospective use of these young men as doctors at a later date. They support this contention with the argument that many doctors at present in the military service will be released by 1948 and 1949.

"An alternative suggestion has been that the Army agree to supply qualified premedical students by selecting from young men now in the armed forces those who had previously been engaged in a course of study in the premedical years and who had already completed at least a year of military service. This would, of course, involve selection of medical students by the Army, rather than by the medical schools. It would involve picking out young men from remote areas like the Aleutians, North Africa and the South Pacific and transporting them back home.

"Up to now, government officials have apparently comprehended the need for maintaining continuous medical education of a high standard in the United States. Evidently the pressures on them have caused them to abandon this view and to gamble on the future of health in this country. The available statistics indicate that persistence in the policy now prevailing will mean disastrous conditions in the years to come. About 3,500 doctors die each year in the United States. If the armed forces are to take 3,300 out of 6,440 in each medical class, leaving the balance of 3,110 to be filled by women and physically defective men, the situation five years from now will be hazardous. There will be an actual deficit of physicians coming into the profession each year.

"The statement that men will be released from the armed forces by that time sufficient to compensate for the deficit in new graduates shows a complete lack of comprehension of the needs of medical service. Where will our hospitals secure interns and residents? Where will the specialist branches in medicine secure the men who will be willing to undergo three to five years of additional training to qualify? Who will take care of the veterans in the greatly expanded medical care program of the Veterans Administration? Who will supply the needs of our allies and, particularly, the people of the liberated countries, where medical schools have been closed and physicians taken as prisoners to take care of the laborers from their own countries deported into Germany? What about the great program of extension of advanced medical education to our neighbors in South America? What about the tremendous needs of China for modern medical aid, which is so strongly emphasized by all of the leaders of our government? At a time when the whole world is confronted with a need for well trained physicians as never before, American officialdom is apparently willing to cut off the supply at its very source.

"By June, young men now engaged in premedical education will begin to be inducted into the service. Letters pour into the headquarters office of the American Medical Association from leaders in education, from physicians and from citizens everywhere urging that everything possible be done to halt this folly.

"The situation has been complicated by the fact that a committee representing the Council of the Association of American Medical Colleges and another representing the American Dental Association have agreed with the director of the Selective Service System that the taking of young men from the armed forces after they have completed at least a year of military service will be a satisfactory solution to the problem. From this agreement the Directing Board of the Procurement and Assignment Service, the Council on Medical Education and Hospitals [of the American Medical Association] and many leaders in medical education strongly dissent. The Council on Medical Education and Hospitals is convinced that the plan cannot insure an adequate supply of qualified medical students. The argument has been offered that the Selective Service System was able to carry out a similar program successfully for the supplying of coal miners and copper miners. Any one familiar with the requirements of premedical education will realize that there can be no analogy between these two situations. The continuing production of physicians of a high standard of education should have precedence because of the fundamental de-

mand for such services at all times by the armed forces and because the needs of our civilian population now and in the future cannot be met by the education of men who are physically substandard and of women. It is, to say the least, uneconomical to spend the time, the effort and the money necessary to put a boy through a premedical course, a medical course and an internship when his physical condition is such as to indicate a lessened life expectancy and the possibility of invalidism in the future. Ten years of service to the people at the end of his career will be of far more value from every possible point of view than ten years at the beginning.

This problem is certainly of grave concern not only to the healing professions and to the medical schools, but to every citizen of the United States in that it strikes at the very foundation of health service to all the people. One of the saddest features of the whole matter is that it demonstrates the tendency of Washington officialdom to disregard the opinions and advice of the only segment of our population qualified by training and experience to plan satisfactorily to meet the health needs of America.

Certainly the situation is grave enough to justify letters of protest from every physician in West Virginia to our senators and representatives in Congress.

The House of Delegates of the American Medical Association at the recent session in Chicago went on record strongly urging the Congress to intervene and legalize the necessary deferment.

GHOST TO WALK AGAIN?

In a syndicated article by Lawrence Sullivan, headed "Bureaucracy Runs Amuck," printed as Chapter IX of a series and appearing in the June 10 issue of the papers served by King Features, Inc., the author states that when "the bureaucrats set out to take over a new field of business or a new profession, the first manifestation usually is an intensive 'smear campaign' against the existing order."

When the Washington drive was against private enterprise, the American business man became a 'Modern Macauley,' or a 'Corporal of Disaster'; in the campaign against the electric utilities, every privately owned power company suddenly became an 'Octopus'; in the fight to take over the Supreme Court of the United States, the slogan 'nine old men' was coined; and now, says the author, "to pave the way for socialized medicine, we hear persistent mouthings of such cliches as 'the tragedy of medicine.' Ignored, evidently, is the fact that, under the inspiration of American professional standards, the United States has developed and sustained the most effective and ideally distributed system of medical care ever achieved in any nation."

The author calls attention again to the fact that, (1) during the past 150 years the average life expectancy in the United States has been extended from 35 to 62 years; (2) a child born in 1942 had a life expectancy of 12 years longer than a child born in 1900; and, (3) during the last 40 years the death rate in the U. S. has been reduced from 17.55 per thousand population to 10.60. "Gone from our presence," he says, "are the ancient plagues of leprosy, smallpox and typhoid. Diphtheria has been conquered; tuberculosis, pernicious anemia, diabetes and a number of lesser ailments have been brought under practical control. Sensational progress in dietetics has improved the health and energy of the whole nation."

Within six months after the Supreme Court's decision in the famous anti-trust proceeding against the American Medical Association and the District of Columbia Medical Society, the Wagner-Murray-Dingell bill was introduced in Congress. "Under this bill," says Sullivan, "the practice of medicine would become an airtight monopoly of the Federal Government. Thus has every power of bureaucracy been mobilized to advance socialized medicine....."

Lawrence Sullivan has sounded a warning that can well be heeded by friends of medicine everywhere. Although we hear but little of the Wagner bill from members of

Congress at the present time, we are told that groups are still hard at work trying to sell the people of this nation on the idea of socialized medicine. The ghost of the Wagner-Murray-Dingell bill may be expected to walk again after the election.

APPOINTMENT PLEASES

The new quarters of the Cancer Control Division of the State Health Department have been opened at 1719 Washington Street, East, Charleston, and Dr. Paul R. Gerhardt, the director, is now at work arranging to take over from the Department of Public Assistance the care of indigent cancer cases in this state.

Preparatory to opening his office, Doctor Gerhardt has consulted with officials of cancer control bureaus in New York, Massachusetts and Connecticut, and has discussed mutual problems with the cancer control directors of Michigan, Iowa, Missouri, Illinois and Wisconsin.

The educational program is already well under way, with papers being presented before local groups in cooperation with the Woman's Field Army.

The appointmentof Doctor Gerhardt as the director of the Division of Cancer Control is recognized officially in the following editorial which appeared in a recent issue of the Bulletin of the American Society for the Control of Cancer:

The Journal of the A. M. A. for March 4, 1944 announces the appointment of Dr. Paul Gerhardt as Director of the new Division of Cancer Control of the West Virginia State Department of Health.

Dr. Gerhardt comes to this newly created position with a background of experience as Director of the Bureau of Medical Services in the Department of Public Assistance in which capacity he has come into intimate contact with one phase of the cancer problem.

Dr. Gerhardt's appointment was made by Dr. John E. Offner, state health commissioner, under the provisions of an act passed at the 1943 session of the legislature. The new division is authorized to set up cancer diagnostic and treatment clinics in the hospitals meeting certain standard minimum requirements.

In the establishment and operation of clinics the division is to consult and cooperate with the West Virginia State Medical Association. Free diagnostic service and treatment are to be furnished needy patients within the limits of funds available for the purpose.

Dr. Gerhardt is working very closely with the West Virginia Division of the Women's Field Army as well as with the West Virginia State Medical Association.

We extend to the State of West Virginia our congratulations on a very progressive and forward looking step and to Dr. Gerhardt our sincere good wishes for a successful inauguration of an extremely valuable program.

CHEWING GUM FEVER

I had forgotten that muscular effort produced a local rise in temperature until last summer when, after tests for undulant fever, typhoid, malaria, etc., on a child, I discovered that on discontinuing the use of chewing gum the temperature became normal. A whole family troubled with fever became normal when the chewing gum habit was discontinued.

On September 20, 1943, each of 10 nurses was given a piece of chewing gum and requested to record her own temperature at the beginning of the hour and for every five minutes thereafter. For 30 minutes she was to chew the gum, then to discard the gum but continue the record. The thermometer interfered with the chewing of the gum one minute out of every five.

Chewing produces a physiologic elevation of oral temperature. The amount of elevation depends on the amount of muscular effort used in the chewing. Chewing gum can produce a false fever that may confuse a diagnosis.—*H. B. Searcy, M.D., in the Journal of the Medical Association of Alabama.*

PHC LICENSES DOCTORS

The Public Health Council has announced the licensing of the following doctors who successfully passed the examination for licensure conducted May 1-2-3, at Charleston: Robert A. Crawford, Jr., Donald Grae Hassig, and Jesse Martin Kirby, Charleston; Walter Justis Glenn, Jr., Fairmont; Harold Hardin Cashman, Morgantown; and Elmer Wayne Baker, Point Pleasant.

General News

WEST VIRGINIA DOCTORS TO VISIT ASHFORD GENERAL HOSPITAL IN JULY

The annual conference of the Sixth Councillor District of the West Virginia State Medical Association will be held Saturday and Sunday, July 15-16, at Ashford General Hospital, White Sulphur Springs. The district embraces the membership of Kanawha, Boone, Fayette, Raleigh and Greenbrier Valley Medical societies.

Attendance will not be limited to doctors residing in the sixth district. Following a conference with Drs. Andrew E. Amick, of Charleston, and W. P. Bittinger, of Summerlee, district councillors, Colonel Beck has made the invitation general so that all the members of the State Medical Association may have an opportunity to observe the work that is being done to rehabilitate the hundreds of sick and wounded soldiers who are being sent there from battlefields all over the world.

Scientific Program

Supper will be served in the officers mess at 5:45 P. M., Saturday and a comprehensive scentific program will be presented in the auditorium of the hospital beginning at 7:30 o'clock. Adequate time will be allowed for a question and answer period following the presentation of each paper. The complete program follows:

Major E. N. Pleasants, M.C., War Time Neuropsychiatry.

Captain J. W. Riley, M.C., Hanging Casts in the Treatment of Fractures of the Humerus.

Lt. Colonel J. W. Pennock, M. C., and Major W. A. Antopol, M.C., Lupus Erythematosus Disseminatus.

Major George C. Prather, M. C., Genito-Urinary Injuries of Warfare.

Major R. H. Kumstaadter, M. C., Coccidioidomycosis of the Lung.

Major R. P. Kelly, M.C., Colles' Fractures, Technique of Reduction.

Major M. L. Kramer, M. C., Medical Jaundice as Seen in the Army.

Captain F. W. Cooper, Jr., M.C., Pencillin Therapy.

Overnight Accommodations

Doctors attending the conference will be guests of the staff of the hospital. Bed accommodations will be provided without charge for over one hundred guests. After the limit is reached in reservations, doctors may obtain rooms at a small cost at any of the several desirable hotels at White Sulphur Springs or nearby Lewisburg. Meals will be served in the officers' mess at the nominal charge of thirty-five cents per person per meal.

It is necessary that an estimate be furnished concerning the number of doctors who will attend the meeting, and all who expect to be present should notify Dr. Andrew E. Amick, District Councillor, Medical Arts Building, Charleston, without delay. Acceptances will be transmitted to hospital authorities and beds will be assigned in the order in which reservations are made.

Ward Rounds

The conference will get under way with a luncheon at the officers' mess at 12:30 o'clock Saturday afternoon, July 15, at which the address of welcome will be delivered by Colonel Beck. Following the luncheon, ward rounds will be conducted as follows:

Medical Service Section

2-3 P. M.—Duodenal Ulcer with X-Ray Demonstration, Captain H. L. Monroe, M.C., Ward 405.
Catarrhal Jaundice—Its Study and Treatment, Captain Joseph Post, M.C., Ward 401.
Clinical Neurology and Psychiatry, Major E. N. Pleasants, M.C., Room 458.

3-4 P. M.—Rheumatic Fever with Cardiac Complications, Major T. W. Maloney, M.C., Ward 404.
The Arthritides with X-Ray Demonstration, Captain N. R. Abrams, M.C., Ward 402.
Malaria, Major R. H. Kunstadter, M.C., Ward 406.

Surgical Service Section

2-3 P. M.—Fractures of Femur, Captain Paul L. Reith, M. C., Ward 601.
Methods in Physical Therapy, Captain Carl Levenson, M.C., and Staff, Physical Therapy Dept.
Demonstration of Urologic Conditions, Major George C. Prather, M.C., Urologic Clinic, Sixth Floor.

2-4 P. M.—Vascular Injuries: Aneurysms, Buerger's Disease, Raynaud's Disease, Frost Bite, Lt. Colonel D. C. Elkin, M. C., and Staff, Ward 206.
Peripheral Nerve Injuries: Repair of Skull Defects, Major George L. Maltby, M.C., and Staff, Operating Room.

3-4 P. M.—Application of Plaster, Major R. P. Kelly, M.C., aand Staff, Orthopedic Clinic, Sixth Floor.
X-Ray Demonstrations, Major Robert C. Pendergrass, M.C., X-Ray Clinic, Sixth Floor.
Diagnostic and Treatment Clinic, E.E.N.T. Conditions, Major Cecil B. Hert, M.C., and Major J. M. Masters, M. C., EENT Clinic, Ground Floor.

Ward rounds will be repeated Sunday morning for the benefit of doctors who will be unable to reach White Sulphur Springs in time for the Saturday rounds.

Golf Courses Open

The golf courses will be open to visiting doctors Saturday afternoon and all day Sunday. There will be no green fee. Doctors may also use the tennis courts and other recreational facilities at the hospital.

RELOCATIONS

Dr. S. S. DuPuy, who has been medical director for the New River Company at Cranberry, has moved to Scarbro, where he will replace Dr. P. E. Prillaman, who has moved to Ronceverte. Doctor Prillaman is connected with the Greenbrier Valley Hospital. Dr. W. G. Moran, of Fireco, succeeds Dr. DuPuy, at Cranberry.

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Dr. Lloyd G. Caylor, of Highcoal, has located at Knoxville, Tennessee, preparatory to reentering industrial practice there.

* * *

Dr. Jerome E. Andes, former director of the University Health Center at Morgantown, is now located at Flagstaff, Arizona.

* * *

Dr. D. W. Mitchell, who has been located at Ronceverte for several years, has moved to Arlington, Virginia.

* * *

Dr. Doff D. Daniel, of Eccles, has located at Beckley.

* * *

Dr. F. J. Moore, of Affinity, has moved to Killarney.

* * *

Dr. W. J. Judy, who has been in practice at Parkersburg for several years, is now located at Beckley.

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Dr. Earl H. Kirk, of Welch, is now attached to the staff of Clinch Valley Hospital, at Richlands, Virginia.

* * *

Dr. John B. Traul, of Omar, has moved to Ward.

WEST VIRGINIA NURSE IN CHINA

Lt. Edith G. Rawe, of New Martinsville, is the first West Virginia nurse to be assigned to a hospital unit in China. According to a War Department release, she was one of nine Army nurses who served in hospitals in Assam, India, pending the establishment of their unit.

IMPORTANT CHANGES IN BY LAWS MADE BY HOUSE OF DELEGATES AT WHEELING

Several important changes in the by laws of the West Virginia State Medical Association were made by the House of Delegates at the annual meeting at Wheeling, May 15-16, 1944. The comprehensive report submitted by the special committee was accepted almost *in toto*. The committee was composed of Dr. J. Howard Anderson, of Hemphill, chairman and, Drs. James L. Wade, of Parkersburg, and F. C. Hodges, of Huntington.

All of the suggested amendments to the constitution offered by the committee will be acted upon by the House of Delegates next year, and the proposed amendments are printed elsewhere in this issue of The Journal.

The following important changes made in the by laws are now in effect:

Dues

Dues will be payable annually on January first, and a member whose dues have not been paid by April first will be automatically dropped from membership and cannot be reinstated except by a majority vote of the members of his society taken prior to the end of the calendar year. After that time such former member must file application for membership instead of reinstatement.

If dues are paid after June 30 by any new members, only one-half of the amount of the fixed annual dues shall be collected; however, all members who are dropped from the rolls on April first and are reinstated during the calendar year must pay the full amount of the dues.

Officers and Committees

The officers are now to be elected by the House of Delegates at such time during the annual meeting as may be fixed by the scientific work committee. The old by laws provided that they were to be elected on the evening of the first day immediately following the president's address.

The president is authorized to appoint all standing committees except the publication committee, and the committee on maternal welfare and child welfare. Members of committees are to serve during the calendar year next succeeding their appointment, except the members of the scientific work committee whose terms of office begin on the date of appointment and end at the next annual meeting. The duties of committees are specifically outlined in the amended by laws.

LIBRARY OF THE
COLLEGE OF PHYSICIANS

The members of the maternal welfare and the child welfare committees are to be selected from the congressional districts by the delegates present at each annual meeting. The chairmen of these two committees are to be appointed by the president.

The terms of all members of the publication committee will now begin on January first and end on December thirty-first, each new member being elected for a term of five years, as in the past.

The name of the committee on conservation of vision is changed to the "committee on conservation of vision and hearing." Besides this committee, new standing committees include cancer, D. P. A. advisory, fact finding and planning, industrial health, publicity, and syphilis. Some of these committees have heretofore functioned as special committees appointed by the president. The syphilis committee will consist of four members to be appointed by the president, and the effective dates of appointment will be staggered so that not more than one member retires from the committee each year.

Merger of Societies

Chapter IX was amended to give to two or more component societies the right to merge into one society. The merger must be agreed to by a vote of the majority of the members affected. The charter of the society losing identity as such is to be surrendered to the House of Delegates.

The new by laws provide specifically for the election of alternates to the House of Delegates. All such alternates who are called upon to serve in place of delegates are to be given all the rights and privileges of delegates.

The entire chapter on the medical defense fund, reestablished by the House of Delegates May 22, 1930, was stricken from the by laws.

V. D. BUREAU CHANGES

Dr. John C. Hume, USPHS, who has been serving as Venereal Disease Control officer at Wilmington, North Carolina, has been detailed as acting director of the Bureau of Venereal Diseases of the West Virginia State Health Department to succeed Dr. L. S. Saler, USPHS, who has been transferred to Baltimore. Doctor Saler has been acting assistant director of the Bureau for the past three years. Dr. Wilfred H. Zhwalen, of Logan, Venereal Disease control officer for the southwestern West Virginia District, has been transferred to the Kanawha Valley Medical Center at Charleston, replacing Dr. L. M. Zell, who has been assigned to Wilmington, Delaware.

PROPOSED AMENDMENTS TO THE CONSTITUTION

The following amendments to the Constitution of the West Virginia State Medical Association, offered at the annual meeting at Wheeling in May by the special committee on the Revision of the Constitution and By Laws, will be submitted to the House of Delegates for final action at the 77th annual meeting at Clarksburg in 1945:

Article VI

Section 1. Amend first sentence to read as follows. "The Council shall consist of the Councillors, and the President, Vice Presidents, and Treasurer *ex officio*."

(The two vice presidents are not now members *ex officio* of the Council).

Article VIII

Section 2. Amend by striking out section 2 and inserting in lieu thereof the following: "Section 2. The place for holding each annual session of the association shall be selected by the House of Delegates and the date fixd by the Council."

(This section now provides that the date shall be "designated by the committee on arrangements representing the component society that is to entertain this association.").

Article IX

Section 3. Amend by striking out the section and inserting in lieu thereof the following: "Section 3. Officers of this Association shall be elected by the House of Delegates at each annual meeting."

(Under the section now in force, officers must be elected "on the evening of the first day of the annual session, immediately following the president's address").

Article XI

Section 1. Delete first two sentences and insert in lieu thereof the following: "Section 1. Funds shall be raised by an annual per capita assessment of dues against members of the Association. Dues in the amount of $15 shall be paid by each such member in the manner provided by the By Laws."

(The first two sentences in this section now read as follows: "Funds shall be raised by an equal *per capita* assessment on each component society. The amount of this assesssment shall be fixed by the House of Delegates, but shall not exceed the sum of Ten Dollars ($10.00) *per capita per annum*, except on a four-fifths vote of the delegates present.").

NEW DENTAL HYGIENE DIRECTOR

Dr. William H. Rumbel, of Hubbard, Ohio, has been appointed director of the Bureau of Dental Hygiene, State Health Department to succeed Dr. Stephen V. Luddy, who has accepted a position with the City Health Department at Alexandria, Va.

WESTON DOCTOR CERTIFIED

Dr. Theresa Ora Smaith, of Weston, was certified by the American Board of Pediatrics at the examination held in New York, March 25-26, 1944.

OVER SIXTY WEST VIRGINIA DOCTORS ATTEND A.M.A. MEETING AT CHICAGO

More than sixty West Virginia doctors attended the 94th annual meeting of the American Medical Association at Chicago, June 12-16. Both of the delegates from West Virginia, Drs. Walter E. Vest, of Huntington, and Ivan Fawcett, of Wheeling, were in their seats at all sessions of the House of delegates, Dr. Vest serving as a member of the committee on amendments to the constitution and by laws.

Doctor Bloss Honored

Dr. James R. Bloss, of Huntington, was elected to the important office of Chairman of the Board of Trustees, succeeding Dr. Roger I. Lee, of Boston, who was named president elect of the American Medical Association. Dr. Bloss was a member of the House of Delegates of the A.M.A. from 1922 to 1935 and has served as a member of the Board of Trustees since that date.

Programs of scientific sections were presented before capacity audiences. Particularly was this true of symposiums on tropical diseases and the use of penicillin and the sulfonamides.

West Virginia Doctor Exhibits

The Scientific Exhibit at the Palmer House was probably the most interesting of any that has ever been arranged, and three levels at the Stevens Hotel were required for technical exhibits. Dr. K. G. Khorozian, of Pineville, was in personal charge of his interesting exhibit on "Microkaryocytes, the Fourth Corpuscular Elements of the Blood and Tissues."

Medical Service and Public Relations

The meeting of chairmen of medical service and public relations committees and state secretaries, held Sunday, June 14, was attended by representatives of nearly all the states, Dr. Louis H. Bauer, of Hemstead, N. Y., Chairman of the A.M.A. Council on Medical Service and Public Relations, announced that regional meetings will be held early in the fall to enable representatives from the different states to present their views and map programs for the future.

Doctor Bauer was elected member of the Board of Trustees to succeed Doctor Lee, but will retain membership on the Council as a representative of the Board. Dr. John H. Fitzgibbon, of Portland, Oregon, succeeds Dr. Bauer as chairman of the Council.

Procurement and Assignment

At an open meeting devoted to the work of the Procurement and Assignment Committee, all of the members of the Directing Board were present. Dr. Frank H. Lahey, the chairman, announced that, as of June 13, 1944, 54,096 doctors were serving with our armed forces. Speakers discussed at length the new policy of Selective Service, under which there will be no deferments of pre-medical students over 18 years of age after July 1, 1944. This policy is contrary to the views held by members of the P. & A. Board, who feel definitely that these students should be permitted to finish their medical education.

War Meeting

At the war meeting held at Medinah Temple, Major General Norman T. Kirk, Surgeon General of the U. S. Army, told thousands of interested listeners that "in this war, not one American soldier has died of tetanus, typhoid, typhus, yellow fever, or bubonic plague." He stated that an average of but three out of every one hundred wounded soldiers admitted to Army hospitals die, as against eight in World War I. He said that the mortality rate in pneumonia has been reduced from 24% to seven-tenths of one per cent, and that the death rate in meningitis has dropped from 34% to 4%.

He said further that the personnel of the medical department of the Army now totals more than 600,000.

Admiral Ross T. McIntire, Surgeon General of the U. S. Navy, spoke at the same meeting, and stated that we now have the lowest rate of venereal diseases in the Navy that has been reported for the past 42 years.

Attendance Over 7,000

The attendance for the five-day meeting totaled 7,284. The following is the complete list of West Virginia doctors registered at convention headquarters at the Palmer House:

Randolph L. Anderson, Charleston; Glenn Ashworth, Philippi; Oscar B. Biern, Huntington; Ben W. Bird, Princeton; Thomas H. Blake, St. Albans; James R. Bloss, Huntington; Altamont H. Bracey, Welch; John J. Brandabur, Huntington; Isadore Erwin Buff, Charleston; John E. Cannaday, Charleston.

Eugene S. Carter, Jr., Boomer; C. T. Clark, Iaeger; Ivan Fawcett, Wheeling; S. Oscar Fry, Charles Town; Cole D. Genge, Huntington; Paul Robert Gerhardt, Charleston; D. E. Greeneltch, Wheeling; R. O. Halloran, Charleston; Israel Hanenson, Man; E. Bennette Henson, Charleston.

Wilbur E. Hoffman, Charleston; C. J. Holley, Wheeling; Dean L. Hosmer, Bluefield; Harold H. Howell, Madison; Frank M. Huff, Bluefield; Felix A. Irmen, Huntington; G. G. Irwin, Charleston; Carl Edward Johnson,

Morgantown; E. Lloyd Jones, Wheeling; K. G. Khorozian, Pineville.

Major Ralph H. Kunstadter, MC, Ashford General Hospital, White Sulphur Springs; H. V. King, Morgantown; Lt. Col. L. Rush Lambert, MC, Charleston; Frank C. Long, Jr., Point Pleasant; John I. Markell, Princeton; John M. Masters, White Sulphur Springs; Ulysses G. McClure, Charleston; S. Elizabeth McFetridge, Martinsburg; Roy Ben Miller, Parkersburg; L. E. Neal Clarksburg.

Major R. C. Pendergrass, MC, Ashford General Hospital, White Sulphur Springs; Wilson S. Phillips, Wheeling; Cecil O. Post, Clarksburg; Philip Preiser, Charleston; Albert M. Price, Charleston; Capt. Clara Raven, MC, Martinsburg; W. N. Rowley, Huntington; D. M. Ryan, Hinton; David E. Sauer, Kingwood; Charles E. Smith, Terra Alta.

Margaret Stemple, Morgantown; Alfred C. Taylor, Mona; John B. Traut, Ward; S. W. Treadway, Wheeling; Thomas Harry Vernon, Clarksburg; Walter E. Vest, Huntington; George Washington Walden, West Hamlin; Halvard Wanger, Shepherdstown, Major Howard G. Weiler, MC, Wheeling; E. D. Wise, Fairmont; Milton Wolpert, Chester.

DR. CHIPMAN RESIGNS

Dr. Lenore P. Chipman, Director of the Division of Maternal and Child Hygiene in the State Health Department since 1942, has resigned to return to private practice at Williamstown, Kentucky. No successor has been appointed.

The E. M. I. C. program was set up in West Virginia under the supervision of Doctor Chipman and figures compiled by the division show that 5,334 maternity cases have been approved from the date the program started (May 12, 1943) to June 1, 1944. The figures further show that 2,401 cases had been completed to that date.

A total of 705 West Virginia doctors are participating in the program at the present time and a total of $209,543.45 had been spent on cases up to June 1. In addition to the doctors who have qualified under the program, 29 osteopaths and 2 midwives are also participating.

AMERICAN BOARD OF OPHTHALMOLOGY

The American Board of Ophthalmology has announced that examinations will be held in 1945 as follows: Los Angeles, in January; New York City, in June; and Chicago, in October. All examination dates are contingent upon war and transportation conditions. Executive offices have been moved to Cape Cottage, Maine, and all correspondence should be sent to the Board at that address.

ONE ADVANTAGE OF HIGHER EDUCATION

The great advantage of going to a university is that you never can regret that you did not.—*Anon.*

NEWTON D. BAKER GENERAL HOSPITAL DEDICATED AT MARTINSBURG JUNE 9

The 2,000-bed Newton D. Baker General Hospital, at Martinsburg was dedicated at exercises held Friday afternoon June 9, at which former governor, John J. Cornwell was the principal speaker. The hospital was formally received by Colonel E. L. Cook, Commanding officer, from Colonel Gilbert Van B. Wilkes, of Pittsburgh, representing the Army engineers responsible for its construction. Other speakers on the program included Major General Norman T. Kirk, Surgeon General of the Army; Major General James L. Collins, of Columbus, Ohio, commanding general of the Fifth Service Command, and Congressman Jennings Randolph, of Elkins.

Hospital Covers 30 Acres

The hospital, representing an investment of over $5,000,000, is located about four miles east of Martinsburg, on the Charles Town pike. The 85 buildings constituting the main unit are corridor-connected and cover about 30 acres in the center of a 185-acre tract of land.

All the facilities necessary for a well-run community are found within the hospital. There are two mess halls, a telephone exchange, post office, and post exchange—the Army's famous "PX." The hospital also houses a library, gymnasium, laundry, and fire department. A guest house and chapel are located on the grounds.

West Virginia Doctors on Staff

A West Virginian, Lt. Col. Thomas N. Arnett, M.C., of Clarksburg, is the executive officer at the hospital. He served as master of ceremonies at the dedicatory exercises.

Colonel Arnett, who received his early education in the public schools at Clarksburg, graduated from West Virginia University with the degrees of A. B. and B. S. He received his M. D. degree at the University of Maryland and served his internship at the U. S. Naval Hospital in Washington. He was with the medical department of the Navy from 1931 to 1936, and has been with the medical department of the Army since that date, specializing in general surgery.

Two other West Virginia doctors, Major Howard A. Swart, of Charleston, and Captain Ira F. Hartman, of Buckhannon, are on the staff at the hospital.

WITH DOCTORS IN THE SERVICE

Captain Joe N. Jarrett, of Oak Hill, who has been stationed at Miami Beach, Florida, has been transferred to the Station Hospital, at Truax Field, Wisconsin.

Captain Harry E. Baldock (center), with two officers of his unit, on a recent visit to Egypt where he accompanied a contingent of wounded soldiers. Captain Baldock is attached to a field hospital in Iran.

Major Paul R. Revercomb who has been attached to Stark General Hospital, at Charleston, South Carolina, recently spent a few days in Charleston prior to reassignment to the 120th General Hospital, at Camp Van Dorn, Mississippi.

* * *

Lt. Commander E. V. Jordan (MC), USNR, of Charleston, is assigned to the Station Hospital, at Camp Wallace, Texas. He was formerly stationed at the U. S. Naval Hospital at Bainbridge, Maryland.

* * *

Lt. Colonel S. S. Bobes, of Wheeling, is chief of medical service at the Station Hospital, Camp Campbell, Kentucky.

* * *

Lt. Harold E. Muller (MC), USN, of Huntington, who was formerly stationed at Camp Joseph Pendleton, Oceanside, California, recently graduated from the school of aviation medicine at Pensacola, Florida, and is now assigned to the 9th Marine Aircraft Wing, M.C.A.S., Cherry Point, North Carolina.

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Captain Harry E. Beard, of Huntington, battalion surgeon at an invasion base depot in England, is in charge of one of the dispensaries at the overseas supply base. He and the members of his staff look after the medical needs of the troops operating the depot.

* * *

"I hope that you had a good convention at Wheeling," writes Major James G. Ralston, of Clarksburg, from somewhere in England. "I only wish that I could have been there. Plan a good one for next year, for we're expecting to finish this job real soon, and hope to be able to attend next year's meeting at Clarksburg.

* * *

The following is the first letter written after D-day that has been received from the European Theater of Operations:

7 June, 1944.

My dear Mr. Lively:

I surely enjoyed your letter of recent date. Am sorry you can't be here to share the invasion with us. But, from what I hear on the radio and read in the papers, America is really celebrating it too.

Morale is extremely high, and it is almost impossible to keep the patients in the hospitals. Some with minor wounds threaten to "go over the hill" to get into the attack. We are plenty busy.

It surely braces you up to see endless waves of bombers cross the channel to blast hell out of Hitler. You can actually feel the vibrations from the terrific explosions.

I haven't seen Claude Smith since I wrote you last, and don't know exactly where he is now. I'll bet that Doctor Hutchinson is hard to replace at Welch. I'll drop him a line soon.

We still don't have too much to drink, but manage to get along on our monthly six ounces of scotch. We were lucky enough to get an ice box for our officers' club, and now have cold beer. One of the nurses found two peaches in town and paid $1.40 each for them. I mean for each peach—not a bushel.

All the West Virginia members of the unit are fine, and the nurses are doing a swell job.

I surely enjoy all the dope you put in The Journal about the West Virginia doctors here and yonder. It is the only way we can find out where they are. I had lunch with Captain Jack Hancock, of Welch, last week, and we decided to send Dr. R. H. Edwards, of Stevens Clinic, Welch, a piece of shrapnel. Best of luck.

Sincerely,
Arnold Wilson, Major, M. C.
(Welch).

* * *

During the past six months, Major Fred E. Brammer, of Dehue, has seen service in Trinidad and Porto Rico. He is now commanding officer of the 301st Station Hospital, most of the personnel of which is assigned at the present to the 298th Station Hospital at Miami, Florida.

Major Brammer reported that he had seen Major Ward Wylie, of Mullens, while he was in Trin-

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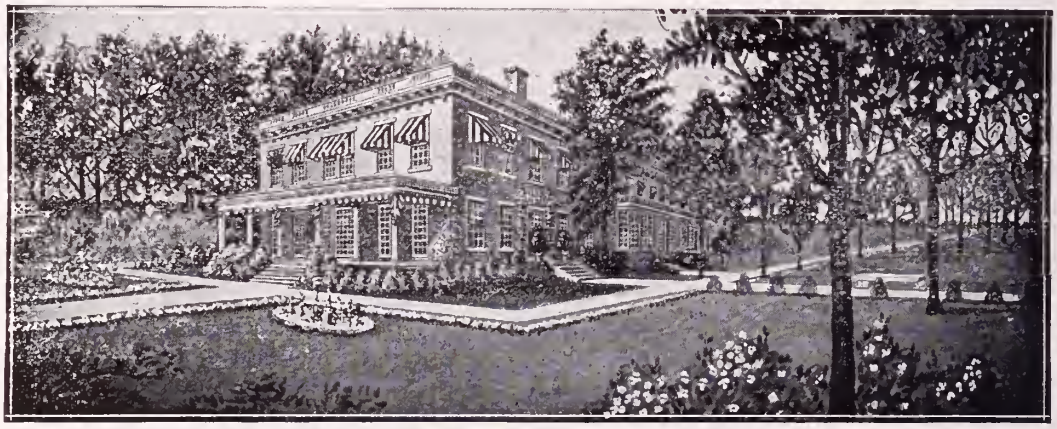

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idad, and says that he has now been transferred to the states. Referring to the Sixth Councillor District conference to be held at Ashford General Hospital, July 15-16, Major Brammer reminds us that Dr. Ashford, for whom the hospital was named, served for quite a while with the Army Medical Corps in Porto Rico after the Spanish American War. He says that the principal street through the nicest residential section of Santurce is named "Dr. Ashford Avenue." Major Brammer has sent us a desk name plate made from native purple heart wood. It is a beautiful piece of wood and so heavy that it sinks in water.

* * *

Captain John H. Trotter, of Morgantown, who has been stationed at Torney General Hospital at Palm Springs, California, is now assigned to the Station Hospital at Kingman, Arizona.

* * *

Captain James E. McClung, of Richwood, writes from England under date of June 5, furnishing us with a new address. He is now serving as flight surgeon for a bomber squadron. "I cannot say much with reference to the type of work I am doing at the present time," he says, "except that it is much different than delivering babies at 3 A. M. on Cranberry Ridge up in Nicholas County." Captain McClung had just returned from two weeks detached service at an RAF base in Southern England.

* * *

Captain Clinton B. Chandler, of Iaeger, has been transferred from Camp Santa Anita, California, to the 132nd Station Hospital at Camp Rucker, Alabama.

S. O. S.

In practically every letter received from West Virginia doctors serving with our armed forces favorable comment is made concerning the "With Doctors in the Service" section of The Journal. We are asked not only to continue, but to enlarge this feature. We expect to do this, but we need the help of members who are in every part of the world.

We need more letters and we need "action" snapshots from which cuts may be made. The Journal is dated and issued on the first day of each month. Our deadline for all purposes is the 19th. of the preceding month. Help strengthen the morale of your confreres in the service by continuing to send us letters that can be reproduced in The Journal.

Entrance to Grounds

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Lieutenant Jack T. Gocke, of Clarksburg, formerly attached to the 252nd AAASl. Bn., Flushing, New York, is now at Camp Stewart, Georgia.

* * *

Lt. Colonel Bert Bradford, Jr., of Charleston, writes from England (May 28) that all of the men in the service there are immensely pleased with the Italian campaign and hope that the campaign from the English bases will work out as well. Colonel Bradford furnishes us with the address of two West Virginia doctors, Captain Gordon L. Todd, of Princeton, and Major T. R. Boling, of Grantsville. Since receiving this letter we have learned that he is now with the invasion forces in France.

* * *

New APO addresses have been received during the past month for the following members of the Association: Captain L. J. Pace, Princeton, Captain Owen A. Groves, Lt. Commander Russel Kessel, and Captain Charles E. Staats, Charleston; Captain Eugene R. McNinh, Weirton; Captain W. L. Claiborne, Huntington; and Captain Cecil W. Shafer, Spencer.

* * *

The following West Virginia doctors graduated May 17 as aviation medical examiners following a course at a school of aviation medicine: Lt. Harry F. Coffman, II, Keyser; Captain Olin M. Goodwin, Buckhannon; and Captain Louis C. Kossuth, Wheeling.

* * *

Lt. Col. Everett H. Starcher, of Earling, who was formerly attached to the Army Recruiting office at Huntington, is the second West Virginia doctor to be assigned for duty in China, the other being Lt. L. B. Gang (MC), USNR, of Huntington. Colonel Starcher left Camp White, Oregon, last February, and was stationed in Africa and India until late in May, when he was transferred to China. No copy of the West Virginia Medical Journal has been received by him since he left the states, and in furnishing us with his new address, he says, "you can't imagine how very much The Journal is appreciated by one so far from West Virginia."

* * *

Lieutenant R. G. Smith, of Beckley, has been ordered to active duty, and is now stationed at Carlisle Barracks, Pa.

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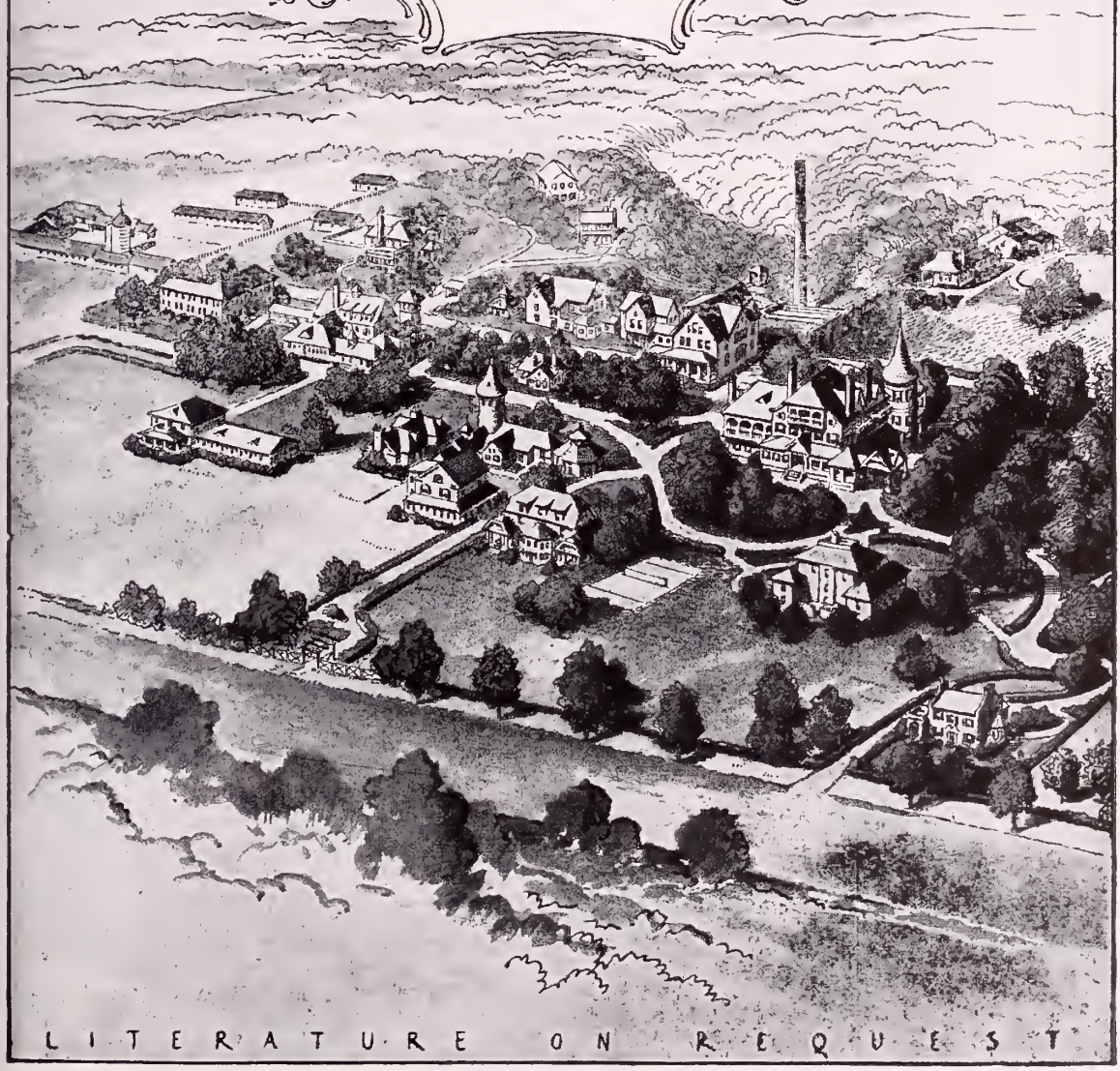

LITERATURE ON REQUEST

Dr. Mendel W. Smith, formerly of Keystone, who is assigned to the 2606th AAF Base Unit at University, Alabama, was recently promoted to the rank of Captain. He is Post Surgeon for the units located at the University of Alabama. "Each month," he writes, "I look forward to receiving The Journal. I especially enjoy reading your news articles on doctors in the service. I keep in close touch with the doctors in Tuscaloosa and the Army doctors at Northington General Hospital in that city, and have attended many medical society meetings in this area."

MOBILE X-RAY UNIT FOR TB BUREAU

The bureau of tuberculosis of the state health department has purchased and will put into service in the fall a new Westinghouse mobile X-ray unit, with a capacity of 800 to 1000 films per day, equipped with a Morgan timer and facilities for taking standard 14x17 films. The unit will be used throughout the state for survey purposes, and will be particularly valuable in industrial surveys.

Civilian psychoneurosis is now at an all-time low in Great Britain.—*W.S.R. in The Detroit Medical News.*

County Society News

CENTRAL WEST VIRGINIA

The spring meeting of the Central West Virginia Medical Society was held in the Community Hall, at Gassaway, April 27, dinner being served by the ladies of the Methodist Church.

The principal address of the evening was delivered by Dr. J. E. Cannaday, of Charleston. He spoke on the subject of dermal tissue in the treatment of hernia and other surgical conditions. Interesting slides in connection with Dr. Cannaday's paper were presented by Dr. J. Bankhead Banks, of Charleston, and a roundtable discussion was led by Dr. J. F. Lembright, of Clarksburg.

Resolutions of respect to the memory of Captain Clayton Calvin Carson, M. C., of Gassaway, the first West Virginia doctor to lose his life during World War II, were adopted and ordered spread on the record.

The July meeting of the Society will be held in Nicholas County.

J. M. COFER, M. D., *Secretary.*

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FAYETTE

A dinner meeting of the Fayette County Medical Society was held at Glen Ferris, May 9, with Dr. Upshur Higginbotham as the guest speaker. He presented an interesting paper on "The Management of Arthritis. The paper was discussed by Dr. Ernest Wolff and others.

E. S. CARTER, JR., M. D.,
Secretary.

KANAWHA

A symposium on sulfonamides, with Dr. W. C. Stewart serving as moderator, was presented at the regular meeting of Kanawha Medical Society, held in the auditorium at the Thomas Jefferson Junior High School, Tuesday, June 6. Interesting papers were presented by Drs. George P. Heffner, H. H. Ritter, H. W. Angell, T. G. Reed, and Boris Beskin. Subjects included general medicine, surgical usage, eye, ear, nose and throat usage, genito-urinary usage, and pathology as related to the sulfonamides. The papers were discussed by Drs. Philip Preiser, G. G. Irwin, D. A. Dent, E. B. Henson, F. C. Kluth, and W. J. G. Putschar.

At a business meeting following the scientific session, Dr. George Miyakaw was elected to membership in the Society.

Full cooperation in the present E.M.I.C. program was expressed in a resolution offered by Dr. Andrew E. Amick and adopted by the members. However, in the same resolution, the Society went on record as disapproving any extension of the program, but approving the recommendations of the fact finding and planning committee of the State Medical Association with reference to the E.M.I.C. program.

W. P. ELKIN, M. D.,
Secretary.

PARKERSBURG ACADEMY

At the regular monthly meeting of the Academy of Medicine of Parkersburg, held May 24, 1944, a medical-surgical plan proposed by a committee appointed several months ago was approved subject to certain changes which are to be made by the board of directors. The committee was composed of Drs. James L. Wade, Fred J. Potter, and A. R. Sidell.

The medical-surgical plan will be completely organized and presented to the public under the

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W. F. ROGERS, M. D.,
Secretary.

SURVIVAL OF THE FIT

Changes in the environment, sometimes slow, sometimes rapid, and the adaptation of life to them, are being constantly demonstrated, and natural history, so far back as discoverable records go, shows that those forms of life that could not adapt themselves to changes in their surroundings had perforce to perish. The sabre-tooth tiger and the mastodon, once lords of the terrain over which they roamed, are known to us only through crude, prehistoric drawings and an occasional pile of mud-encrusted bones; the giant saurians, maintaining themselves on the lush vegetation of the muck age, succumbed when these conditions changed, and have left us, to remember them by, only their skeletons and a few gigantic footsteps.—*New England J. of Med.*

NATIONAL FOUNDATION FELLOWSHIPS

To provide men and women professionally trained in public health work who will aid the nation's army of polio fighters, The National Foundation for Infantile Paralysis has set aside the sum of $50,000 for fellowships in health education.

Under this program, which has been developed in cooperation with the U. S. Public Health Service, qualified men of certain Selective Service classifications, as well as qualified women, will go into training starting this fall.

A fellowship in health education covers a stipend to the trainee of $100 monthly for twelve months; tuition and university fees to the school; and expenses for field service. Applications are obtainable from the Office of the Surgeon General, U. S. Public Health Service Washington (14), D. C. Applications must be accompanied by a transcript of college credits and a small photograph, and must be in the Office of the Surgeon General not later than August 15, 1944.

DURING FOOD SHORTAGES

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REFRESHER COURSE IN OTOLARYNGOLOGY

The University of Illinois College of Medicine announces that its fall didactic and clinical refresher course for specialists in otolaryngology will be held at the College from September 25 to 30 inclusive. The fee for the course is $50.00. Since registration is limited to twenty-five, applications should be filed as early as possible. Write for information to Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

TUBERCULOSIS ABSTRACTS

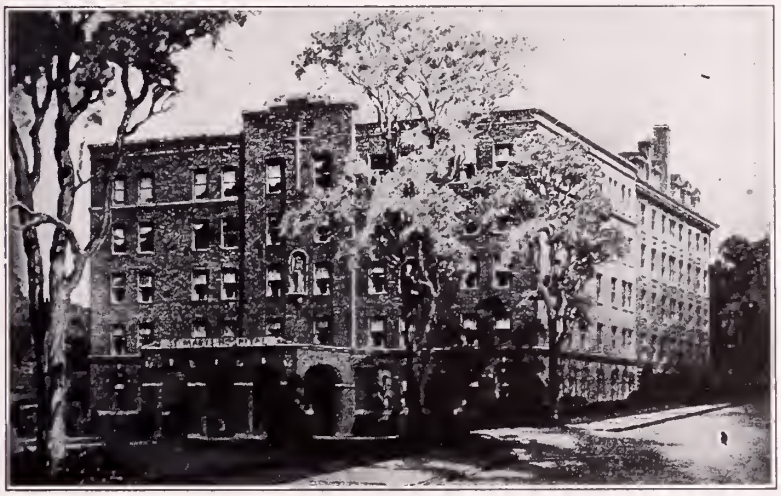
Continued from page 234

The Treatment of the Tuberculous Woman During Pregnancy

Pregnancy was advised at one period as a preventive or curative measure. Later the opposite course was advocated and therapeutic abortions were advised in all cases where the pregnancy was discovered before the fifth month.

Gradually the treatment of tuberculosis has become an attempt to control the tuberculous process itself. In this change of emphasis the necessity of aborting the pregnant tuberculous woman came to be questioned. Most of the adverse reports on the effect of pregnancy on tuberculosis came from obstetricians who compared the normal pregnant woman with the tuberculous pregnant woman. A study of tuberculous women, both pregnant and non-pregnant, was undertaken directing the main effort of therapy against the diseased process rather than against the normal physiological process to the end that the tuberculous pregnant woman could go to full term without interfering with her recovery

SAINT MARY'S HOSPITAL
Clarksburg, West Virginia



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Approved for Serology by the West Virginia State Department of Health.

Weekly Outpatient Tumor Clinic as suggested by the American College of Surgeons.

from tuberculosis.

The woman with active tuberculosis should have bed rest plus such additional methods of treatment as pneumothorax and other collapse therapy which would be used if pregnancy were not present. Following labor more intensive treatment may be indicated to prevent a spread of the disease.

The arrested case of tuberculosis who becomes pregnant after leaving the sanatorium should receive more careful prenatal care than if tuberculosis did not exist. Many return to the sanatorium for care. Treatment varies with the condition. In general they receive modified bed rest for two or three months prior to delivery and strict bed rest for a month or six weeks following delivery.

Treatment of the pregnant woman with tuberculosis by the most modern means of combating the disease, together with equally modern prenatal care, apparently offers her as good a chance for recovery from her tuberculosis as though pregnancy did not exist.

The Treatment of the Tuberculous Woman During Pregnancy, E. S. Mariette, M.D., Leonard M. Larson, M.D., J. C. Litzenberg, M.D., American Journal of the Medical Sciences, June, 1942.

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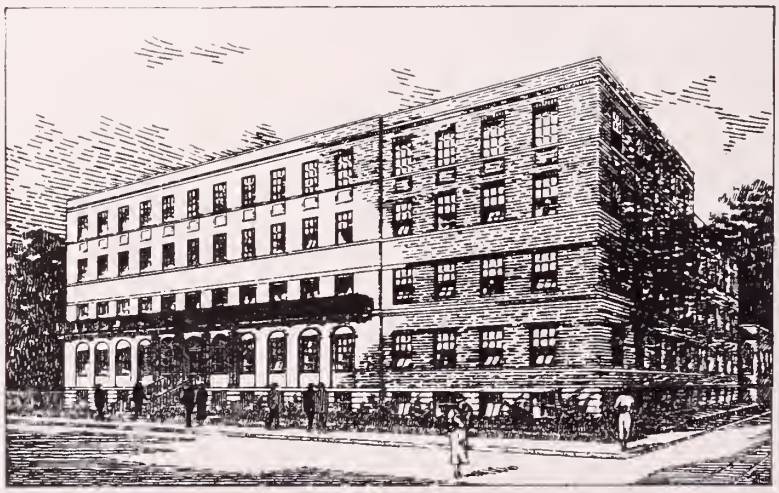

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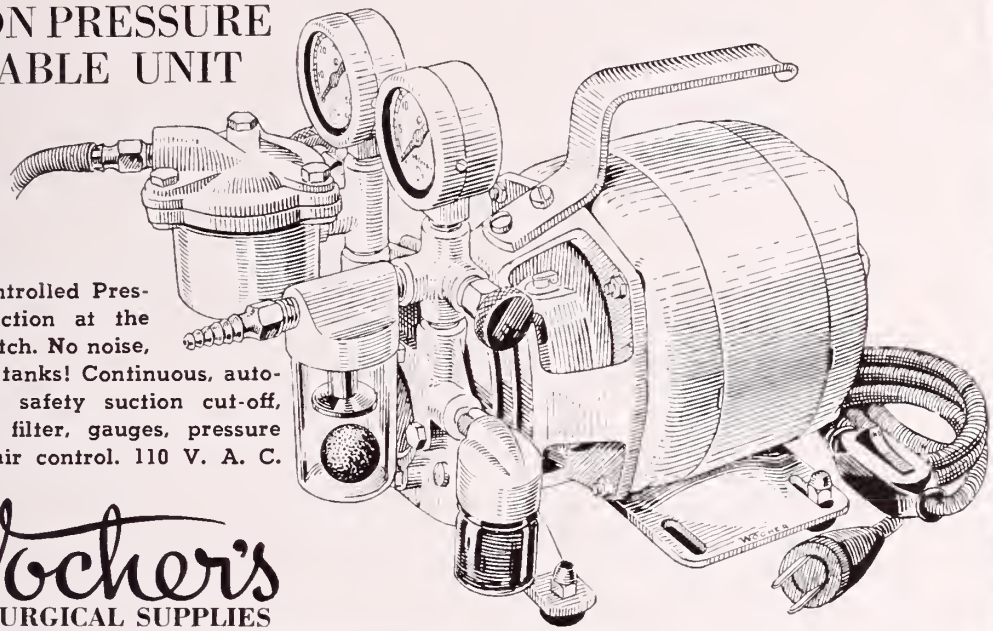

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TRAUMATIC INJURIES OF THE KIDNEYS*

By GEORGE C. PRATHER, Major, MC, AUS,
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War casualties have focused interest upon traumatic injuries of all parts of the body. While urinary tract injuries in military and civilian life do not occur as frequently as injuries to some other body regions, e. g., the extremities, prompt recognition and proper treatment of urological cases remain essential for the welfare of the patient.

The most frequent incidents which produce renal trauma include vigorous flank contact, as in football or in training, bullet and shrapnel penetration, falls from trees, and sled or bicycle collisions with motor vehicles.

The following statements and recommendations are based on personal data accumulated during civilian practice and observations of military personnel weeks after they received renal injuries.

Since the treatment of renal trauma is based primarily on the type and extent of the injury, the first consideration must be an understanding of the types of injury, a simple classification of which follows:

1. Contusion: The kidney is bruised, perhaps slightly swollen, but the renal capsule is intact and no gross rent in cortical substance is evident.
2. Subcapsular laceration: The kidney appears slightly enlarged due to edema and subcapsular hemorrhage, but the renal capsule is intact. There is a tear or fissure in cortical tissue which may or may not involve a calyx.
3. Capsular rupture: Both the renal capsule and cortex show gross laceration. One or more calyces are usually involved, permitting blood and urine to permeate the perirenal tissue. Transverse fracture of the kidney is not uncommon.
4. Injury to the pedicle: This type of injury is rare. It is not necessarily immediately fatal. (1)

Although there may be variations in extent and location of the injury, the above commonly accepted subdivisions serve to

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form an adequate and relatively simple working classification.

Repeating the fact that the choice of medical or surgical treatment is based primarily on the type of injury, one's first responsibility is to determine the extent of renal damage. This diagnostic feat is not always easy. Furthermore, possible trauma to structures adjacent to the kidney such as the transverse processes of vertebrae, vertebral body, peritoneum or intraperitoneal organs merits consideration.

COMMON FEATURES REVIEWED

The common features of most kidney injuries can be reviewed with the idea of emphasizing certain points which may be helpful for an accurate diagnosis. Gross hematuria is the most common clinical sign. Pain in the affected side is the most common symptom, but the pain in the affected costovertebral or lumbar region is not necessarily in proportion to the extent of renal damage. Patients with complete transverse rupture of the kidney incurred during athletics have walked off the field and have not suffered intense discomfort even hours later when the excitement of the moment had passed. Gross blood or clots passing down the ureter may fail to produce a colicky type of pain. (2) It is possible that the pain per se is primarily due to injury of muscular or bony tissue near the kidney, rather than to injury of the kidney itself. Furthermore, it is often difficult to differentiate between lumbar and costovertebral tenderness of renal origin and that caused by contusion of nearby muscle or bony structures. Following trauma, pain and tenderness in the corresponding upper abdominal quadrant may be more indicative of renal injury than symptoms over the lumbar region.

Although it is not possible to determine accurately the extent of renal trauma by flank pain and tenderness alone, pain and tenderness which develop in the lower abdominal quadrant on the corresponding side in conjunction with other evidence of psoas spasm indicate extravasation of perirenal blood and/or urine. The clinical findings mentioned in the preceding sentence usually manifest themselves twelve to thirty-six hours after injury, and indicate true rupture involving the renal capsule, a condition which demands surgical intervention. These features have proved invaluable in pointing to the need for operation before significant changes in blood pressure occur, and in some instances when intravenous pyelography has failed to demonstrate positive evidence of rupture. Tenderness in the corresponding lower abdominal quadrant and other signs of psoas spasm as an indication for surgery have not been stressed by other authors in communications of this subject.

Hematuria is invariably present in those patients with kidney injuries unless the pedicle is severely damaged or the ureter bisected. The color of the urine may vary from smoky or pink when contusion is present, to red or scarlet urine thick with clots when more damage has occurred. In general, the degree of hematuria is in proportion to the extent of the injury, but the degree of hematuria does not enable one to differentiate true rupture from subcapsular injury. If a patient with suspected renal injury cannot void, immediate catheterization is indicated.

SHOCK

The presence or absence of shock due to renal injury is variable, but the presence of severe shock immediately arouses suspicion of visceral injuries in addition to those of the kidney. Contusion of the kidney does not produce shock except perhaps in elderly or debilitated individuals. Those who have subcapsular rupture are rarely seen in shock, and even those with complete rupture infrequently show manifestations of shock unless there is accompanying intraperitoneal trauma. Low blood pressure and rapid pulse in patients with signs and symptoms of ruptured kidney are usually primarily due to hemorrhage rather than shock.

As this discussion proceeds it should be evident that in our diagnosis we are trying to establish whether the kidney injury is of the nature of a contusion or subcapsular rupture, neither of which requires surgical treatment,

or whether capsular rupture is present, a condition which usually requires surgical treatment.

Pyelography is of aid in attempting to establish the extent of the trauma, although it is not infallible. An x-ray film of the urinary tract is first viewed in an effort to establish renal outlines, presence or absence of renal shadows, abnormality of spine or bony pelvis, or an abnormal abdominal gas pattern. Intravenous urography can be carried out with reasonable assurance of success if systolic blood pressue is above ninety mm. of mercury. By this procedure we endeavor to demonstrate the presence and efficiency of the kidney on the uninjured side, the secretory ability of the injured kidney, the contour of the pyelographic pattern, and an intact bladder. Intravenous urography is to be preferred to retrograde study, at least as an initial measure.

RESULT OF A CONTUSION

Failure of the injured kidney to secrete sufficiently for visualization may be the result of a contusion, in which case the kidney will be found to be performing normally five to seven days later. On the other hand, failure of the injured kidney to secrete the media may indicate considerable damage. It is in this latter instance that the clinical signs mentioned earlier in this paper become valuable in helping to determine whether or not surgical intervention is advisable. Should pyelographic media be visualized beyond the limits of the renal outline, rupture of the capsule as well as cortical tissue is evident. However, in those cases with subcapsular rupture, the pyelographic media can be seen peripheral to a calyx, but still confined beneath the capsule. The majority of those cases with minor contusion exhibit a normal urogram, although an apparently normal pyelogram is not positive evidence of a less serious injury.

The probable diagnosis of the various types of renal injury is therefore arrived at by careful study of physical signs (whether static or changing), observations of the urine, and data from pyelographic study.

If it is possible to decide what type of renal injury is present, treatment can be carried out with reasonable assurance of a good result and the avoidance of undesirable sequelae. Contusion of the kidney requires only rest for recovery. Subcapsular injuries do not require surgical treatment unless there is associated renal disease which interferes with normal recovery. True rupture of the kidney may sometimes heal without complications, but the danger of continued perirenal oozing of blood and/or urine, with subsequent abscess, and the danger of continued bleeding which leads to a depleted and dangerously delayed preoperative state make it advisable to proceed with surgery as soon as the diagnosis is indicated by clinical or pyelographic examination.

In those cases in which there is no suspicion of intraperitoneal injury, a retroperitoneal flank approach is preferable. Blood and urine will have at least partially freed the kidney from the fatty capsule so that the kidney can be exposed and delivered quickly. It is then a matter of surgical judgment as to whether simple drainage of the perirenal space with or without suture of the renal tear will suffice, or whether nephrectomy is desirable.

INJURIES IN CIVILIAN LIFE

Renal injuries in civilian life caused by gunshot wounds, and those in military service caused by bullets or shrapnel are commonly associated with abdominal or chest injuries. Under such circumstances, immediate surgery is advisable, and the abdominal approach is recommended. Repair of injured abdominal viscera takes precedence over repair of the injured kidney. Following repair of abdominal organs, transperitoneal nephrectomy can be accomplished when necessary. We have had opportunity to observe battle casualties who have had repair of stomach, intestinal and mesenteric wounds, in addition to transperitoneal nephrectomy close to the front lines overseas. These soldiers, as the result of prompt and excellent surgical treatment in the theatre of operations, have made

a splendid recovery and have been returned to duty after convalescence and study of their postoperative renal status.

Experience with renal injuries leads one to be optimistic concerning the end result in the majority of patients, provided intelligent and prompt care is available.

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SPORADIC MENINGOCOCCUS MENINGITIS*

(REPORT OF TWO CASES)

By WILLIAM P. BOGER, M. D.
Bluefield, West Virginia

MENINGOCOCCUS meningitis or cerebrospinal fever is a disease whose very name strikes terror to the heart of the layman, and there is some justification for this feeling. Of this disease it has been said, "No disease so quickly slays." (1) The death rate of untreated meningococcus infections, although it varies from epidemic to epidemic, has been reported as between 20 and 90 per cent. (2) (4). However, with the advent of the sulfonamides the mortality rate has fallen to 3.5 per cent. (3). The chance of recovery from this dread disease has been increased many fold but the need for early diagnosis is still imperative.

During an epidemic, when cases are common, the physician is on the alert and at such a time even the laity appreciates the significance of the "stiff neck," but in those times between epidemics or when our own community seems to be happily removed from the hotbeds of contagion, the sporadic cases of meningococcus infection arise to puzzle us.

Reports of two such cases follow:

Case 1.—No.46073-F.B., a white male, age 13, was admitted at 1:45 p. m. on January 6, 1944 and died the same afternoon at 6:10 p. m. The patient was irrational during the brief period of observation and the history of the case was obtained from his mother.

The boy had complained of headaches for the past month, a symptom of which he had never before complained. He was otherwise well. On January 3 the lad complained of headache so severe that he could "scarcely hold his head up" but he insisted upon attending school. At noontime he came home for lunch but felt too ill to return to school. He was put to bed, shortly began to vomit, and remained ill throughout the night. The next day he complained of general aching over the body and particularly of the neck and back. Vomiting continued and he remained in bed and became progressively worse. During the day of January 5 he began to "talk out of his head" and through the night he became delirious and violent. A physician was called on January 6 and, noting the retracted neck, the delirium, and the vomiting, immediately made a diagnosis of meningitis. The patient was sent to the hospital and arrived at 1:45.

Spinal puncture was done immediately and grossly purulent cerebrospinal fluid was obtained. A smear of this fluid revealed very many intracellular and extracellular gram-negative diplococci.

The patient was in a state of agitated delirium but when quietly spoken to and gently handled he cooperated to a slight extent. He complained wildly, "I can't see!" and indeed, the pupils were widely dilated and no blinking occurred when the hands

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*Presented before the Mercer County Medical Society, Bluefield, West Virginia, March 16, 1944.

were waved directly before his eyes. The head was sharply retracted, the neck rigid, and cries of protest were elicited by the slightest flexion of the neck. Kernig's sign was present bilaterally. The skin was carefully examined for rash and none was found. The lungs were apparently clear. The heart rate was rapid, there were no murmurs and no thrills, blood pressure was 100 systolic and 70 diastolic. The abdomen was soft, and the spleen was not enlarged. The patient lay on his side with the knees and hips flexed. There was no evidence of arthritis.

Intravenous medication was not at hand so a Levin stomach tube was passed and 3 gm. of powdered sulfadiazine and several ounces of warm water were administered. At hourly intervals three ounces of warmed fluid were given by way of the tube. At 4:15 p. m. the patient appeared quieter, the abdomen was not distended, respirations were quiet and regular, and his condition was apparently somewhat more favorable. At 6:10 p. m. without warning, he ceased to breathe and respirations could not be reestablished even though intravenous coramine was given and intracardiac adrenalin was administered.

Laboratory findings: red blood cell count, 6,080,000; hemoglobin, 108 per cent (Sahli); white blood cell count, 25,500; differential count, 89 per cent; polymorphonuclear, 11 per cent lymphocytes. The culture of the spinal fluid revealed a pure and luxuriant growth of meningococci.

Necropsy examination: An autopsy was done fifteen hours after death. Permission was not granted for examination of the brain and spinal cord. The lower lobe of the left lung showed a small patch of bronchopneumonia but the lungs were otherwise normal. The heart was normal in size and appearance; the valves were normal; the myocardium of the right ventricle was 2 mm. thick; that of the left ventricle was 7 mm. thick. The abdominal viscera presented no abnormality; there were no petechiae on any of the visceral surfaces. The kidneys were of average size and the capsules stripped readily. The adrenal glands were not hemorrhagic and presented a normal orange-yellow color. The ureters were patent; the urinary bladder was not distended and contained 200 cc. of clear urine. The only significant finding was the presence in the stomach of much of the sulfadiazine powder which had been administered by stomach tube.

The only cause of death disclosed by necropsy was meningitis.

Comment.—The ignorance of the boy's family displayed in not seeking medical aid sooner, can only be deplored. There were six other children in this family, ranging in age from 3 to 17 years, but despite urging to have them immediately examined, it was not until four days later that they were brought to the hospital. All of these children had exceedingly hypertrophied tonsils; their temperatures were normal, and their necks supple. Epidemiologically it would have been highly interesting to determine whether or not any of these youngsters harbored meningococci in the throat. To date no member of this family has become ill and no other case of meningococcus infection appeared in the community of 30,000 until January 31, as will be shown by the next case report.

MEDICATION NOT SYNONYMOUS

This first case illustrates the fact that administering medication to a very ill patient is not synonymous with treating him. The finding at necropsy of the sulfadiazine in the gastric contents is evidence that the gastrointestinal tract of an ill and febrile patient is not a normally functioning organ. This is a strong argument in favor of intravenous administration of sulfadiazine in such cases.

Case 2.—No. 46223-A.V.R., a white male, age 17, had previously been well but for four or five days had been suffering from a mild "cold" and had complained of feeling a little soreness of his muscles, although he had continued to attend school. On January 31, 1944 the patient was seized with a headache while at school. He began to vomit and was forced to go home, where he was put to bed. The nausea and vomiting continued and he was found to have an elevation of temperature. He spent a restless night and the next morning complained of not feeling well generally and of headache. His father, a physician, noticed a macular rash on the boy's body and suspected a contagious disease. Later in the morning the patient had a "convulsion" and the writer was called in for consultation.

At 10 a. m. on February 1, the boy was examined in his home. His temperature was 102 F., pulse 96, respiration 20, and blood pressure 90 systolic and 60 diastolic. He was alert and cooperative but complained of not feeling well. A macular rash was present over the entire body, on both palms and soles, and on the face. The eruption looked not unlike measles except that on the right hand

and on the ankles were several dark, purple hemorrhagic lesions 3 mm. in diameter, which are highly characteristic of meningococcus infection. The neck was painful on anterior flexion but it was not stiff, and Kernig's sign was absent bilaterally. The lungs were clear and the heart regular. No murmurs were heard and no thrills palpated. The abdomen was soft and the spleen could not be felt. Venous blood was drawn for a blood count and at the same time 2.5 Gm. of sodium sulfadiazine were given intravenously. The patient was transported to the hospital within a short time.

LUMBAR PUNCTURE DONE

As soon as he was admitted to the hospital a lumbar puncture was done, the fluid was not under increased pressure and appeared to be clear. Examination of this fluid revealed 1,600 white blood cells per cubic millimeter, many of them polymorphonuclear cells. No organisms were seen. This spinal fluid was cultured but no growth was obtained (it is only fair to say that the meningococcus is a fragile organism and no special methods were used to enhance growth). The patient was given an additional dose of 2.5 Gm. of sulfadiazine intravenously and also 1500 cc. of 5 per cent glucose in physiologic saline solution. Thereafter the patient was allowed to eat as he was able and was given 1 Gm. of sufadiazine orally every four hours until a total of 25 Gm. had been given.

The boy's course was uniformly favorable and on the second day of illness the fever began to decline and reached normal on the fourth day and remained so until he was discharged from the hospital on the ninth day.

The clinical course was followed closely with laboratory examinations.

Laboratory findings: February 1, 1944 (Initial blood count) red cells 5,050,000; white cells 17,-800; differential count 89 per cent polymorphonuclear, 11 per cent; lymphocytes; hematocrit of 50 per cent.

February 3. Red cells 4,500,000; hemoglobin 90 per cent; white cells, 4,700; 58 per cent polymorphonuclear; 42 per cent lymphocytes. Blood level of sulfadiazine 10 milligrams per 100 cc.

February 4. White cells 3,550. Blood level of sulfadiazine 12 milligrams per 100 cc.

February 5. White cells 4,650 with 55 per cent polymorphonuclear; 35 per cent lymphocytes; 8 per cent eosinophiles 2 per cent basophiles.

February 8. Red cells, 5,150,000; hemoglobin 98 per cent; white cells, 6,300; with 57 per cent polymorphonuclear; 38 per cent lymphocytes; 5 per cent eosinophiles.

Comment.—This case represents the meningococcus infection that passes for a "cold" at its inception and is only recognized when septicemia is proclaimed by the rash and the metastasis to the meninges is evidenced by meningeal signs—in this case a convulsion, a painful neck but not a stiff one, and a cellular response in the cerebrospinal fluid.

We had no qualms about the low white cell counts for the reason that the differential counts revealed a normal distribution of mature blood cells. The appearance of eosinophiles in numbers during the recovery or healing stage of this illness would seem to correspond with the interpretation that their presence in a blood smear signifies a favorable reaction to infection.

It is of interest to note that no other case of meningococcus infection has come to light since the report of this case. Of more than passing interest is the discovery that a school-chum of the patient suffered from meningococcus infection during the past summer (1943) while he was visiting an army camp in Georgia. That the army has had the problem of meningococcus meningitis arising in raw troops is no secret. Thus the epidemiological thread that links one case to another may be tenuous but it is real.

DISCUSSION

Clinical Types of meningococcus infection.—Our concept of meningococcus infections must be a broad one and there must be a full appreciation of the fact that even the sporadic cases do not arise by spontaneous generation. The "carrier" rate in nonepidemic periods is 1 to 2 per cent and during epidemics as high as 30 per cent. (3). Mild meningococcus infections masquerade as the common cold and both Herrick (8) and Rolleston (9) long ago classified an "abortive meningococcus infection" in which the patient becomes convalescent in twenty-four to forty-eight hours, but this fact seems not to be generally appreciated. Thomas (3) even calls attention to three cases that recovered without treatment before it was discovered that their blood cultures were positive for meningococci. Thus there exists a form of meningococcus infec-

tion which is so mild as to pass completely unrecognized.

There is, on the other hand, the fulminating meningococcemia, so-called "purpura fulminans" which causes death in a matter of hours (11). The violence of this form of the disease is such that only after a physician has seen such a case can he fully appreciate it. Great livid subcutaneous extravasations of blood characterize this syndrome; petechiae and purpuric lesions can be seen to appear as one observes the patient who is alert and frequently conscious up to the last. When death supervenes and bilateral adrenal hemorrhages are found at autopsy, the term "Waterhouse-Friderichsen syndrome" is applied.

RASH

Intermediate in severity is the usual case of meningococcus meningitis which has its onset as a "cold," "grippe" or the "flu" and then in succession a rash, headache, nausea and vomiting, and stiff neck appear (case 2). Unfortunately, the rash sometimes does not appear (case 1), and in other cases when it does appear it is mistaken for measles or some one of the exanthems. The mistaking of the rash for a symptom of one of the infectious diseases is excusable because the eruption presents itself in many forms. The rash may be macular or it may be morbilliform; tender nodules that duplicate erythema nodosum lesions may be encountered on the extremities, petechiae are common, and purpuric intracutaneous extravasations of all sizes may be seen. A patient may manifest all the types described above. The rash is evidence of septicemia and positive blood cultures can be obtained in 60 to 80 per cent of the cases (1).

Apart from the acute meningococcus infections there is a chronic form in which meningococci are fed into the blood stream from some focus (sinuses, middle ear infection, nasopharynx), giving rise to a triad of symptoms: chills and fever, rash, and arthralgia which is diagnostic of chronic meningococcemia (20) (21) (23). These cases are apparently uncommon, probably more through failure to recognize them than through their actual rarity. Meningitis nearly always results in these cases.

Thus the meningococcus is capable of producing a number of clinical syndromes. The feeling grows that invasion of the blood stream exists at some stage of every meningococcus infection and that meningitis is the result of meningeal metastasis. With this conception of the disease, it is understandable that meningitis should, in some cases, appear early, in others not at all, and in some only after the existence of a chronic meningococcemia for many months.

Public Health Considerations. — Adams (1) flatly asserts that we know little of the epidemiology of this disease and that we have no way of determining who will become its victims. Certainly, the feeling grows that the disease is one to which most individuals have a high degree of immunity. Of the contagiousness of the condition there need be no question, but the variety of the manifestations of meningococcus infections as outlined above, makes it clear that to pay attention only to the meningitic form of the disease is to show a complete lack of understanding of meningococcus infection. Meningitis of itself "quarantines the patient to his quarters" so that he no longer serves as a mobile vector in the cycle of contagion. But the mild infection which passes for a 'cold" or "mild upper respiratory infection" is the real threat to public health. Both of our cases "attended school" while they were most certainly "carriers" of meningococci, because they appeared to have "only a cold."

COMMON COLD

The common cold is never the innocuous disease which we are prone to think it is, and it is our opinion that the sooner it becomes the common practice to prohibit a child from attending school while he suffers from a cold, the sooner will we see the control of every contagious disease. It would be well if adults would act with intelligence and likewise limit their goings and comings while they suffer from a cold but perhaps this is expecting a little too much.

Quarantine Laws.—The laws with respect to meningococcus infections are in need of revision. The common regulation that "three consecutive negative nasopharyngeal cultures" be obtained before discharge from quarantine has been made completely meaningless by the advent of sulfonamide therapy.

Meningococcus infection responds to treatment with any of the sulfonamides although sulfadiazine appears to be the drug of choice. Treatment with as little as 3 Gm. of sulfadiazine per day for three days, which is less than usually given during active treatment, will result in persistently negative nasopharyngeal cultures (3) (17) (18) (19). It has even been shown in the treatment of persistent carriers that nasopharyngeal cultures became negative within twenty-four hours after the beginning of therapy and remained negative for varying periods of observation up to eight weeks (19).

CONTAGIOUS OR NON-CONTAGIOUS?

How then shall we determine when a patient is in a contagious or non-contagious disease state? It would appear that the display of the same caution which is practiced in the avoidance of a "cold" (which is one of the most contagious of all diseases but for which there is no quarantine) should be practiced for the first twenty-four hours after sulfonamide therapy is begun. Further than this, we believe that technics of isolation are, in most cases, more cumbersome than effective. In determining when a patient is well, we feel there is no set rule, and that each case must be individualized. After adequate therapy has been given (at least 25 Gm.) and the temperature has been normal for at least a week after the cessation of therapy we have found that the ability of the patient to sit up in bed, draw the legs up to the abdomen, and flex the head toward the knees without pain is an excellent practical test of recovery. If the patient can do this simple "exercise" he may be discharged with the advice to "rest-up" for at least another week at home. We must not forget that in spite of dramatic results with sulfonamide medication, these patients have had an active infection of the central nervous system and many of them feel faint, suffer from "dizziness," neurasthenia, and headaches for many weeks.

Diagnosis.—Sporadic cases of meningococcus infection are missed and justifiably, but the fact is nonetheless regrettable. As pointed out in the description of the different forms of the disease, it is necessary that we have a broad concept of the disease and that we always be conscious of meningococcus infection when "colds" are numerous.

Several additional aids to diagnosis may be mentioned. Objective muscle tenderness has considerable significance. All of us are familiar with the subjective complaint of "soreness and aching" in acute febrile illnesses, but in such cases there is seldom objective tenderness. On the other hand, in meningococcus infection the patient may cry out with pain if the calf of the leg be squeezed or if a tourniquet be applied, showing a soreness comparable with the muscle tenderness seen in trichinelliasis or peripheral neuritis. Dickson et al (13) have called attention to the differential value of this finding. It was not present in case 2 but we have observed it in many cases.

The blood examination can be of real value in this disease. No other condition except perhaps lobar pneumonia so quickly gives such a marked leucocytic response, 16,000 to 60,000 with 90 per cent or more polymorphonuclear cells (8). The number of "toxic" granulocytes also plainly indicates severe infection. The direct blood smear may reveal the actual presence of meningococci within some of the leucocytes (3) (14) (15) (16) (23). Blood smears made after scarifying individual lesions of the petechial rash frequently reveal organisms (12). Blood cultures by reason of the time required to obtain positive growths, are more of academic interest than of service in making an early diagnosis.

Therapy.—We have called attention to the advisability, if not the actual necessity, of in-

travenous medication in the case of a very ill patient (case 1). An initial dose of 3 to 5 Gm. of sodium sulfadiazine is adequate and a sufficiently high blood level of the drug can be maintained by giving 1½ to 2 Gm. intravenously every six hours thereafter until oral medication can be given. Once the patient has recovered to the point of tolerating food there is no advantage in the continuation of intravenous medication.

If the patient is able to take the drug by mouth from the beginning an initial dose of 3 to 4 Gm. should be given and followed by 1 Gm. every four hours until a total of 25 Gm. has been given. There can be no hard and fast rules. The optional blood level of the drug to be achieved is a matter of some speculation for cures are numerous when the level has been no higher than 3 to 5 milligrams per hundred cubic centimeters. In our own experience we have found that the dosage schedules cited give levels of 10 and 12 milligrams per hundred cubic centimeters rather consistently if the fluid intake does not exceed 4,000 cc. per twenty-four hour period. Maintenance of fluid balance in these patients is, we feel, highly important but we believe that the blood level of the drug can be influenced to a great extent by the amount of fluid given the patient.

In some quarters (15) there has been a deplorable tendency to overtreat and achieve unnecessary and, indeed, dangerous blood concentrations in the treatment of meningococcus infections. When there is definite evidence that one is dealing with a severe infection it may be well to exceed the usual dosage in order to achieve a high blood level promptly, but routinely there is no such need. Those who say they "never get drug reactions" have failed to observe their cases closely enough.

The use of antimeningococcus serum and antitoxin seems to be indicated only in fulminating meningococcus infections where there seems to be some indication that it helps in the overcoming of "toxicity" arising from the overwhelming infection (3).

A single diagnostic lumbar puncture is, in most cases, sufficient. The only indication for repetition of the puncture is embarrassment of respiration and evidence of increased intracranial pressure such as restlessness, continued headaches, and papilledema. The intrathecal administration of serum is a thing of the past and no longer has any place in the treatment of meningococcus meningitis.

CONCLUSIONS

A brief discussion of meningococcus infections is presented, together with reports of two cases of sporadic meningococcus meningitis, the outcome of one of which was fatal, with autopsy being permitted, and the outcome of the other being prompt recovery after early diagnosis and treatment.

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THE EMERGENCY MATERNITY AND INFANT CARE PROGRAM

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THE Emergency Maternity and Infant Care program is one of a number of recent indications of the increasing interest of health departments in medical care. Medical care is not an innovation to health departments inasmuch as they have engaged for years in programs for the prevention and treatment of venereal diseases, cancer, tuberculosis, malaria, crippling diseases, and others. Medical care administration is new, however, to most divisions of maternal and child health. The successful development of the EMIC program in West Virginia is a tribute to Doctor Chipman and her staff, for the skill and understanding which she has exercised in the face of shortage of personnel and the difficulties of adaptation to an added medical care program.

West Virginia has had for a long time an interesting variety of medical care programs. In addition to those of the health department there are the programs of the Department of Public Assistance for crippled children, for adult physical rehabilitation, and for the people who are receiving relief allowance; there are the program of the Workmen's Compensation Commission, the prepayment plans for miners and their families and, more recently, the prepayment plans sponsored by the state and county medical societies. There are others but these will suffice as examples. These programs have their advantages and limitations but I should like to emphasize their significance. They are the evidence that all of us, governmental and nongovernmental agencies, professional and lay groups, are working together to find the right solution to the problem of providing adequate medical care for the heterogeneous population groups that make up our country. The EMIC program is simply a recent addition to these programs, designed primarily for the care of wives and infants of men in the armed forces.

The EMIC program started in the summer of 1941, when the commanding officer at Fort Lewis, Washington, requested the assistance of the state health commissioner in providing medical care for the families of many of the men stationed there. The wives of these soldiers had moved near the camp to be near their husbands, and the medical staff of Fort Lewis had been providing care

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for them, as was done at many other camps, until their capacity for providing such services was reached. Additional amounts of Fund B were provided the Washington State Department of Health by the Children's Bureau for this purpose. This problem of medical care existed also in other states and so many requests for additional funds were received that a deficiency appropriation for the remainder of the fiscal year was made available to the Children's Bureau in March 1943.

INCREASED FUNDS FOR 1944

Since then, with increased funds appropriated for 1944, there has been a very rapid acceleration of the program, and it is estimated that during the fiscal year 1945 the cost of the program will average more than $3,000,000 a month. At the end of March 1944 nearly 270,000 cases had been authorized. In West Virginia at the end of March 1944 about 4,500 cases had been authorized since the beginning of the program in April 1943. The number of authorizations in March was about 41,000 for the United States of which 548 were for West Virginia. It has been estimated that about 15 to 20 per cent of the 1944 births in this country will be paid for from EMIC funds. In some states with larger cantonments the figure is higher.

The rapid growth of the program is an indication of its extreme popularity with those of the public who are recipients of the service and of the cooperation being given by thousands of physicians. There has also been great interest shown on the part of many lay groups concerned with the welfare of women and children and much favorable comment from members of Congress and representatives of the Army, the Navy, and veterans' organizations. The importance of this program in maintaining the morale of our soldiers and sailors, which is its primary purpose, has been cited in letters from the Surgeons General of the Army and the Navy. I should like to read an excerpt from a letter to Doctor Martha M. Eliot, Associate Chief of the Children's Bureau, from Doctor Norman T. Kirk, Surgeon General of the U. S. Army:

"I would like to augment this statement by telling you personally what an excellent morale factor this program has been, in addition to providing better obstetrical care for thousands of women. Soldiers going to our many overseas theaters of operation go with the knowledge that their wives are being cared for during childbirth, thus relieving them of weeks or months of worry over the uncertainty of what is taking place back home.

"Sincerely yours,

"NORMAN T. KIRK,

"The Surgeon General, Maj. Gen. U. S. Army."

A similar statement was published in a recent issue of the Journal of the American Medical Association. Comments such as these, together with the large number of authorizations made, leave no doubt as to the great value of this program, conducted, as it is, on the basis of providing services.

There are many interesting features in this program. Time does not permit the discussion of more than a few of its principles which have great importance.

The first of these concerns eligibility for services. In the determination of eligibility no financial investigation is involved. The services under the program do not constitute charity; they are a right to which the wives and infants of men in the four lowest pay grades are entitled just as much as we all have the right to send our children to public schools. This right to services has been made clear in discussions with congressional committees and in the remarks made in Congress. This principle, while perhaps somewhat unusual in medical care programs, is not an innovation. The benefits of the Workmen's Compensation Fund, for example, are also available without regard to the individual's ability to pay for his medical care.

A second important principle is that payment for medical care is made, in so far as possible, on a case basis. The physician is paid for the care he gives a patient during that part of the maternity period during which she is under his care, rather than for each visit or service given. The saving in

time and money to health departments by this principle has been considerable. If a fee were paid for each visit or service given, it would be well-nigh impossible to administer the program, so extensive would the paper work become. In the early days of the program it was sometimes difficult for many physicians to appreciate the necessity for such a provision, but I think that with the passage of time, it is now being readily accepted. As you know, in recent years, a number of physicians, particularly pediatricians, have conducted part of their private practice on a case basis, for example, providing services for an established fee during the first year of the infant's life.

A third feature I wish to discuss is the method of payment for hospital care. With the exception of a few groups, hospitals are paid an inclusive rate based on the average per diem cost of each hospital. The method of calculating the cost recommended by the Children's Bureau follows, with some modifications, the procedure described by the American Hospital Association in its manual on "Hospital Accounting and Statistics". Hospitals customarily are paid a rate established somewhat arbitrarily between the hospital and the public agency purchasing care, or on the basis of the rate usually charged the public for such accommodations. These rates usually have no relation to cost and, in fact, have frequently been too low. Such rates in the past have been as low as $1 a day, and many state agencies were paying below $3. About two years ago the Children's Bureau recommended its new policy on the purchase of hospital care. This plan has resulted in general satisfaction on the part of hospital administrators and is regarded as a significant step in the purchase of hospital care by government agencies. Recently this method has been adopted by another federal agency and consideration is being given it by still other groups. The Children's Bureau has been commended many times by hospital representatives for the adoption of this policy.

A fourth feature of the program is the establishment of minimal hospital requirements for participation. Inasmuch as care is being provided in hospitals of all sizes from the smallest maternity home of two or three beds to hospitals having over 1,000 beds, it was evident that some yard stick had to be established whereby state agencies could measure the quality of services being provided in these hospitals. Although the standards for maternity care and care of newborn infants under the EMIC program are not exacting, there are hospitals which do not meet them. Doctor Chipman has visited almost every hospital in this state and has made recommendations to the hospital administrators which have assisted them in raising their standards of services. In many states the initial and follow-up visits are made by a nurse who has had additional training and experience in pediatrics or obstetrics and who is, therefore, in a position to assist hospitals in their nursing technique in the nursery and delivery room and in demonstrating time saving measures to improve the efficiency of the nursing staff. This has brought the health department into closer cooperation with individual hospitals with the purpose of assisting hospital superintendents in making their institutions examples of modern methods of conserving the lives of mothers and infants.

It is now a little over a year since the EMIC program was started in West Virginia. The health department has administered carefully and efficiently, despite the rapidity of its growth, a program that has provided medical care to thousands of wives and children of service men, with the active cooperation of hundreds of practicing physicians. This fact will always stand as a fine contribution of the state to the war effort.

EXCITING FACTORS PRECEDE CANCER

Although in many instances the exact transition into cancer process has not been proved, clinical experience dictates that cancer usually does not become initiated in normal tissue, and the processes frequently seen before the cancer exists have become known as exciting factors.—Don B. Bowers, M.D., in *J. of the Ind. St. Med. Assn.*

THE DISTRIBUTION OF PAIN IN LESIONS OF THE UPPER URINARY TRACT

(REPORT OF CASES)

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All of us are thoroughly familiar with the characteristics of the pain which occurs during a typical attack of colic due to ureteral stone. We know that the pain is severe and agonizing, that it radiates downward along the course of the ureter and that it is usually referred to the external genitalia or inner aspect of the thigh. When the violent pelvio-ureteral peristalsis forces the calculus into a larger portion of the ureter or changes the axis of the stone, the obstructed column of urine breaks by the point of blockage and a calm follows the storm. During the interval between attacks the typical patient may be entirely free from pain or he may have a dull kidney distress due to incomplete drainage or there may be some discomfort in the area of the ureter where the stone is lodged.

The common conception of the pain produced by a large stone lying in the kidney pelvis or embedded in a calyx is that there is a more or less constant dull distress which does not radiate, but which is confined to the kidney region. We associate unilateral costo-vertebral angle pain with this type of stone, though strangely enough, even large staghorn calculi sometimes produce no discomfort. We do not ordinarily expect kindey or ureteral lesions which are not inciting hypereristalsis (manifested clinically by kidney colic) to produce referred pain.

That reflected pain does occur as a constant, nagging, dull ache in structures to which the colicky pain of an acute attack is typically referred, while pain is insignificant or absolutely nonexistent in the organ which is the actual seat of disease will, I believe, be definitely proved by the cases reported in this paper.

*Presented before the Cabell County Medical Society, Huntington, West Virginia, February 10, 1944.

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Pain may manifest itself solely in one of the lower quadrants of the abdomen or in the genitalia when the disease is in the kidney. Similarly, disease of the ureter, notably, calculous disease, may produce pain predominantly or entirely in the external genitalia. Renal pain is occasionally transferred across the cord and felt in the opposite side of the body as though originating in the healthy kidney. This is the so-called renorenal reflex. Hinman tells us that most of the objective pains in urology are felt at a distance from the place of origin.

A brief review of the embryology, neuro-anatomy and physiology of the urinary and genital tracts will serve to show their close relationship and will furnish a basis upon which pain referred from the upper urinary tract can be explained.

Embryologically, the mesonephric or Wolffian duct forms the vas deferens and the epididymis. The ureter, pelvis and calyces also arise as a bud from this same duct. The mesonephros or Wolffian body arises as a bud from the same duct. The mesonephros or Wolffian body which is drained by the Wolffian duct gives rise to the gonads.

The sensory and sympathetic nerve fibers of the renal capsule, pelvis and upper ureter center in the tenth, eleventh, and twelfth dor-

sal and first lumbar segments of the cord which also harbor the cells of nerves that supply almost the whole surface of the body below the level of the diaphragm, so that any surface pain below the diaphragm may be of renal origin by transference in some one of these four segments of the cord. The testicle is also innervated through the eleventh and twelfth dorsal segments, mostly sympathetic and a few cerebrospinal fibers by way of the genital branch of the genitocrural nerve which arises from the first and second lumbar segments and supplies the skin of the scrotum in the male and the labia majora in the female. The ilio-inguinal nerve which supplies the skin of the root of the penis, the skin of the scrotum in the male and the labia majora in the female also arises from the first lumbar segment. When the lower ureter is diseased, pain felt in the external genitalia can be explained by the fact that sympathetic fibers from this area of the ureter enter the inferior mesenteric, spermatic and hypogastric or vesicalplexuses, so that pain is referred along the cerebrospinal nerves of respective segments of the lower lumbar cord. The lower ureteral innervation is in intimate relationship with spinal segments supplying the bladder, penis, scrotum, etc.

Visceral pain is referred to a distant area because the brain receives impulses from the sympathetic visceral terminals indirectly through these segments of the cord by reason of the fact that the nerve cells of these sympathetic fibers are in close association with the nerve cells of the peripheral sensory system. The stimuli brought into the cord by the visceral terminals incite the neighboring sensory cells to react and transmit the impulse to the brain as though it really had originated in the area of peripheral distribution of the somatic nerves, the cells of which lie in this same segment of the cord.

Due to this widespread intercommunication involving the nerve innervation of the urogenital tract, it can be readily seen how the location of pain as interpreted by the patient can confuse one in making a diagnosis.

Hinman believes a complete investigation of the kidney is indicated even without urinary complaint of any kind or any abnormality of the urine itself, in every case of backache of doubtful origin or of suspicious pain in the abdomen, and I agree with him. My exper-

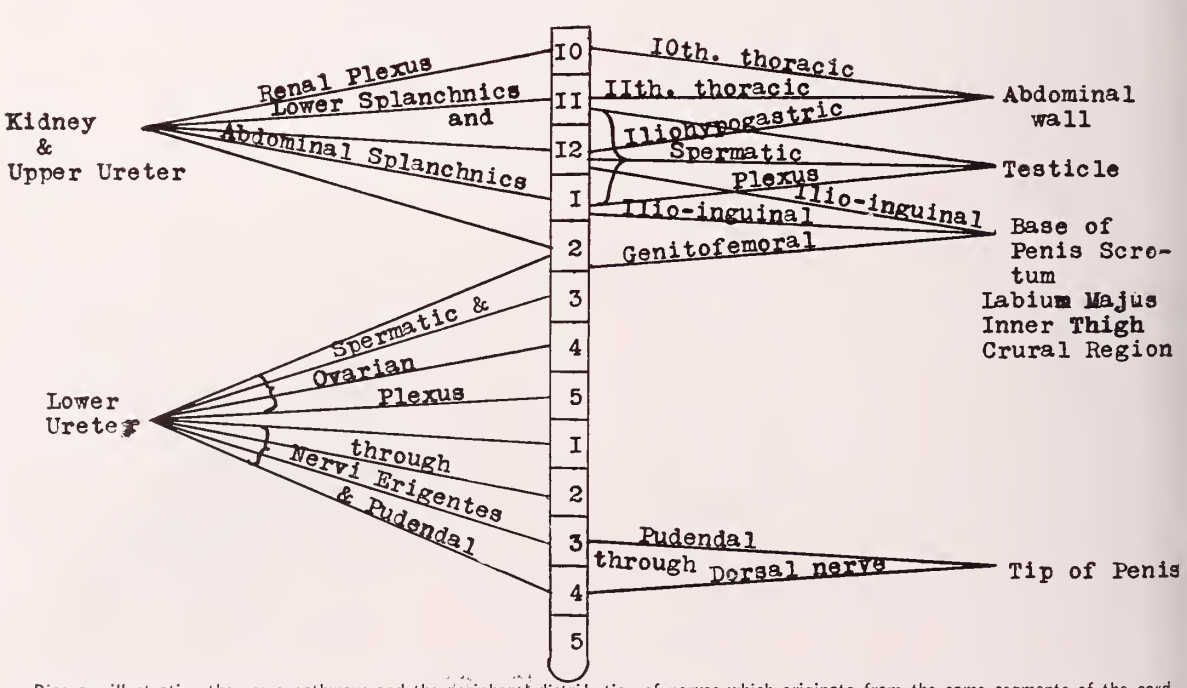

Diagram illustrating the nerve pathways and the peripheral distribution of nerves which originate from the same segments of the cord that supply the kidneys and ureters.

ience leads me to add that an investigation of the upper urinary tract should be made in all cases of pain in the external genitalia unless some very obvious lesion exists in these organs or in adjacent sexual structures.

Case 1.—A 30 year old woman was admitted to Grace Hospital with a diagnosis of acute appendicitis. She complained of pain in the lower right quadrant of her abdomen, and nausea and vomiting which began the day before admission. Examination of her abdomen revealed tenderness and rigidity over McBurney's point. Her temperature was 101 F. There was a mild leucocytosis, and her urine showed pus (2 plus). Because of the latter finding, attention was drawn to the urinary tract. Pyelographic studies revealed a large infected hydronephrotic right kidney with very poor function. The left urinary tract was normal. A nephrectomy was carried out instead of an appendectomy, and the patient made an uneventful recovery. This case demonstrates how a lesion in the right urinary tract may closely simulate appendicitis.

Case 2.—A 65 year old white woman consulted me because of a very annoying discomfort in her external genitalia of three years' duration. She gave a history of having had a complete hysterectomy five years previously because of malignancy of the uterus. Her urine showed a few pus cells. When asked to point out the area of her pain, she placed her hand directly over the left labium majus.

On looking into the bladder the right ureteral orifice was normal and emitted indigo carmine promptly. In the region of the left orifice there was an area of bullous edema about 2 cm. in diameter. Catheterization of this ureter was impossible. Intravenous urography disclosed a normal appearing and normally functioning right urinary tract, but nopyelogram was shown on the left side. At operation a large functionless left hydronephrosis and hydro-ureter were found, and nephrectomy was carried out. This patient at no time had experienced pain in the loin or in the abdomen. Following her operation the pain in the region of the left labium vanished, and she was discharged from the hospital with a feeling of well being.

Case 3.—A white male, age 48, was admitted to the urological service at Grace Hospital for operation upon a left varicocele which was thought to be producing pain in his left testicle. Preoperatively, his urine showed a few pus and blood cells, but this finding was ignored. Operation for cure of the varicocele was done, and apparently a good result was obtained, but the patient continued to complain of a constant dull distress in the testicle. Subsequently, pyelographic investigation showed a large staghorn stone in the left kidney. Because of recurrent attacks of right renal colic, which necessitated surgical removal of a stone from the right ureter, this patient refused surgery on his left kidney. It is my belief that a staghorn stone in the kidney was responsible for the testicular discomfort.

Case 4.—A 30 year old male was admitted to Grace Hospital complaining of pain in the right inguinal canal. He had served one year in the U. S. Army where he was told that he had a relaxed right inguinal ring, and operation for hernia was advised. A preoperative urinalysis showed pus and blood in the urine and a plain x-ray film revealed opaque densities in both kidney areas. On the basis of these findings, he had been honorably discharged from the Army. Cystoscopic and pyelographic examinations showed evidence of a horseshoe kidney with bilateral pelvic stones. Because the pain was on the right side, the right kidney was operated upon and the stone removed from its right pelvis. This patient had never experienced any discomfort in either loin; his pain was confined entirely to the right inguinal region. Following the removal of the stone from his right kidney pelvis, the pain in the inguinal canal promptly disappeared.

Case 5.—A 42 year old white female complained of discomfort in the area of the upper lumbar spine directly in the midline. The pain was worse on exertion, and gave every indication of being due to some orthopedic condition. She was treated diligently by an orthopedist but experienced no relief. A flat x-ray showed a small shadow ½ cm. in diameter in the left kidney region. There was no evidence of arthritis. A pyelogram proved that this shadow was in a terminal midcalyx. Surgical removal of this stone which was accomplished through a small incision in the pelvis of the kidney brought about a complete cessation of the back pain. The type of pain experienced by this individual was certainly not at any time typical of renal calculus.

Case 6.—A physician, age 35, came to the office complaining of rather severe and more or less constant pain in the penis. He gave a history of having passed several stones from the left kidney, and was

aware that there was a final stone in his left ureter. Notwithstanding this fact, he was greatly perturbed lest there might be some intrinsic disease or perhaps a malignant condition beginning in the penis. No evidence of disease could be found in the genital tract. An x-ray film showed a shadow in the lower left ureteral area. Following cystoscopic dilatation of this ureter, the patient, after a rather severe seizure of colic, passed a stone and this brought about complete and permanent relief of the distress in the penis.

Case 7.—A 30 year old man was referred to me because of a constant dull pain in the left testicle of six months' duration. A low grade prostatic infection was found, and appropriate treatment instituted without any effect upon the testicular pain. A course of diathermy was tried without producing relief. As the epididymis appeared somewhat thickened and tender, we performed an epididymectomy, which likewise failed to relieve the discomfort. After a year of annoying distress in the testicle which failed to respond to any relief measure, this patient suffered a severe attack of left kidney colic and passed a ½ cm. stone. Following this the testicular pain disappeared completely. I believe this patient had a stone in the pelvis or upper ureter causing referred pain in the testicle during all the time that he was being treated for testicular neuralgia.

Case 8.—A 70 year old man complained of a constant, dull, testicular pain on the right side, of two years' duration. He also mentioned the fact that he was impotent sexually. He had undergone many courses of treatment directed toward the relief of his pain and impotence but had received no benefit. There were a few pus and red blood cells in the urine. An investigation of the upper urinary tract disclosed the presence of a stone 1 cm. in diameter in an intrarenal right kidney pelvis. There was considerable dilatation of the calyces and crippling of the kidney function.

At operation an effort was made to remove the stone through a nephrotomy incision, as the kidney pedicle was short and the kidney densely adherent. Being unsuccessful in this attempt, a quick nephrectomy was performed since the opposite kidney had proved normal in every respect. After two weeks in the hospital he returned home free of pain, and reported after a two month period that he was completely relieved of the pain in his testicle and that he had returned to work. A communication from him at the end of one year was to the effect that he was feeling fine and that their home had been blessed by the arrival of an eight pound boy.

CONCLUSIONS

1. I feel that these cases prove conclusively that chronic pain due to lesions in the upper urinary tract may occur in peripheral structures only.

2. A plea is made for an investigation of the upper urinary tract in cases of obscure abdominal or back pain and in individuals who complain of discomfort in the external genitalia when no causative lesion can be demonstrated in the genital tract.

WATER SAFETY PROGRAM SAVES LIVES

Time and again, in their military operations, hosts of our boys find themselves in a situation where ability to swim and to handle oneself well in the water means the difference between life and death. We may be thankful, therefore, that a large proportion of American men of service age know how to swim.

Unknowingly, many soldiers, sailors, and marines will owe their ability to swim, and to save themselves and their buddies from drowning, to the work of the American Red Cross and other safety organizations which long before our entry into the war carried on extensive water safety campaigns.

That the efforts of the safety associations have been effective in cutting down the number of deaths by drowning may be inferred from the sharp downward trend over a long period of years in the mortality from this cause among the millions of Industrial policyholders of the Metropolitan Life Insurance Company.

Among white male policyholders, ages 1 to 74, for example, the standardized death rate from drowning in the war years 1942-1943 was 9.9 per 100,000, or 42 percent below the rate of 17.2 prevailing at the time of the last war. Moreover, a substantial drop was recorded at every age period except 1 to 4 years. It is of special interest that declines ranging from 35 to 44 percent were recorded at ages 5 to 24 years, for it is in this age group that maximum death rates were reported, the very highest rate, 16 per 100,000, being found at ages 15 to 19. This is gratifying evidence that the safety campaign has not failed to impress boys and young men in their adventurous ages. Drownings among females also have decreased.

Tuberculosis Abstracts

Furnished Through the Courtesy of
The West Virginia Tuberculosis Association

When an individual with congenital heart disease acquires tuberculosis it is a serious mishap. The medical adviser must then make the choice between conservative treatment of the tuberculosis or using some form of collapse therapy with the attendant risk of burdening the already embarrassed circulatory systems still further. A recent study of a number of cases suggests that prompt and active therapy directed at the tuberculosis offers the best chance of preserving the already short life span of these individuals.

Pulmonary Tuberculosis Associated With Congenital Heart Disease

It is commonly accepted that individuals suffering from congenital heart disease are prone to develop and later to succumb to pulmonary tuberculosis. Of all patients with congenital heart anomalies it is those with pulmonary stenosis who seem most likely to develop tuberculosis. Whether it occurs more frequently in this group than among a comparable number with normal hearts cannot be stated positively without detailed statistical analyses. Case reports seem to show that tuberculosis is no greater menace in patients with pulmonary stenosis than is their cardiac defect.

It is true, however, that many persons born with this anomaly die before they have relatively much opportunity to develop tuberculosis, many of them being so incapacitated that they are protected from infectious contacts. If predisposition does actually exist it must arise primarily in the faulty oxygen and blood exchange characteristic of these cases.

This study concerns the frequency of congenital heart conditions in a tuberculosis institution, the course of the pulmonary disease and the efficacy and advisability of collapse therapy in the face of the cardiac handicap.

In the course of 1,545 necropsy examinations of tuberculous individuals, seven cases of congenital heart disease were discovered, an incidence of 0.4 per cent. The incidence may be higher than in most other tuberculosis institutions due to the fact that one out of eight beds in this hospital is allotted to pediatrics. It is lower than that observed in institutions devoted entirely to the treatment of children.

The diagnosis made from the symptoms and physical examination of six additional patients coincided unusually well with the defects found in the seven cases that came to autopsy. They exemplify the grouping of cardiac anomalies known as the *tetralogy of Fallot*. A picture of this condition is represented by this composite case report: The patient is a white youth in his lower teens. The history records cyanosis from birth or shortly thereafter and the diagnosis of congenital heart disease was made early. At that time the child was placed on restricted activity and followed in a hospital out-patient department. He has had no evidence of congestive failure and has led a fairly normal life until the onset of the pulmonary disease. Examinations show a young-appearing underdeveloped child not, as a rule, dyspneic, but with cyanosis and clubbing of the fingers and toes. The heart is enlarged in all dimensions, with a loud, harsh, systolic murmur at the base, usually associated with a systolic thrill. The lung findings are dependent upon the pulmonary pathology. Laboratory tests indicate a well-marked polycythemia and there are tubercle bacilli demonstrable in the sputum. Roentgenography and flouroscopic examination demonstrate enlargement of both ventricles frequently more marked in the right and a prominent pulmonary conus. The venous pressure is within normal limits and the blood pressure tends to be normal or slightly decreased. In the electrocardiogram are found right axis deviation with tall P waves, these often being notched. The pulmonary disease has not influenced the findings typical of the combined heart lesions making up the cyanotic group.

In the group of cases here reported pneumothorax was instituted in five cases. In one case only was an effective pneumothorax established. In no case did collapse therapy increase the cardiac symptoms or lead to congestive heart failure.

It is recommended that congenital heart disease should not be considered a contraindication to thoracoplasty and in order not to deprive these patients of the few years of life expectancy due them, immediate operation may be more advantageous than a preliminary, often disappointing, trial of pneumothorax.

The Development of Pulmonary Tuberculosis in Congenital Heart Disease, Oscar Auerbach, M.D. and Marguerite G. Stemmermann, M.D., The American Journal of the Medical Sciences, February, 1944.

The President's Page

There never has been, and there probably never will be another weekend just like it! For you men who were unable to attend the Annual Conference of the Sixth Councillor District held at the Ashford General Hospital—"Old White Sulphur"—let me say that you really missed it. To begin with, the weather was delightful, the old "White" never looked better, and from the moment we entered the gate we knew that a real treat was in store for us. From the M. P. who admitted us, to the enlisted men who directed us to our bunks, to the nurses who were lovely and gracious, to the staff that inspired us with intensely interesting papers and conferences, up to Colonel Beck himself, a cordial hospitality was showered down upon us that we will not soon forget.

About 170 West Virginia doctors attended the meeting, 140 of whom slept in comfortable bunks in a new gymnasium opposite the tennis courts. Believe me when I tell you we all slept well in spite of some of the darndest snoring it has ever been my pleasure to hear.

Imagine, if you can, spending a weekend at White Sulphur with free golf, excellent meals at 35c each, and no tips. It sounds screwy but those are the improvements that have been made since the Army took over from the C. & O.

But in addition to this, Colonel Beck and his staff have done a magnificent job. The patients are receiving the best that can be had, not only in the practice of medicine and surgery, but in food, shelter, recreation and rehabilitation; and with it all, the "Old White" is just the same, both inside and out, as you and I have known it.

Some of us arrived early Saturday morning for golf. Saturday afternoon was given over to conferences and ward rounds. Saturday night we listened to eight intensely interesting and instructive papers. Following this, there was a dance for the officers and their wives, as well as other light diversions, in all of which we participated. Sunday morning, more ward rounds for some; golf for others. Sunday afternoon we left tired but happy and deeply appreciative of a most unusual weekend.

It would not be fitting to close this page without a word of commendation to Andy Amick, Bill Bittinger, and Charlie Lively who instigated and arranged this unique and unprecedented meeting. May I offer my humble congratulations to you all, and to any one else who may have played a part in giving so many of us such a grand and glorious time.

President.

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D. D. T.

The outbreak of the war in Europe in 1939 set in motion many things in this country, among which were plans to combat diseases which might threaten our troops in foreign lands. It was early obvious that there was need for better protection against insect-borne diseases, especially typhus.

At the request of the Surgeon General of the Army, extensive research was instituted and carried out by the Committee on Medical Research of the Office of Scientific Research and Development through the Bureau of Entomology, U. S. Department of Agriculture, the National Institute of Health, the Food and Drug Administration, and private investigation. As a result of this research, among other products, there has been introduced into use the fabulous dichloro-diphenyl - trichloroethane, now popularly known as D.D.T.

The tale of this drug is even more incredible than that of sufanilamide. It was originally synthesized in 1874 by a young German chemist, Othmar Zeidler, in Strasbourg. He gave it mention in the Proceedings of the German Chemical Society, and thereafter both drug and chemist dropped into obscurity. A few years ago Muller, Basle, Switzerland, synthesized the product and discovered its amazing insecticidal power. Further research by Geigy, Basle, and the Swiss Federal Experimental Agriculture Station established its place as an insecticide and lousicide.

The published story that Geigy was ignorant of the properties of D.D.T., and that the first lot of it was smuggled out of Switzerland into this country, while a dramatic wartime story, is not true.

The facts are that Geigy had demonstrated the lousicidal properties of the drug, had informed the American Military Attache in Berne of them, and the original shipment to this country was openly effected between Geigy and its American subsidiary, Geigy Company, Inc. When imported into this country, the drug was placed at the disposal of the U. S. Department of Agriculture. Extensive research in this country more than confirmed the results reported from abroad. It soon was evident that D.D.T. killed lice better than anything available. Production on commercial scale was started and is increasing in quantity rapidly. As yet the entire output goes into military and research use.

Mixed with 90% prophyllite, D.D.T. is used as a dusting powder in areas where typhus is present. Introduced under clothing by means of a hand "Flit" gun, it gives protection to the wearer for thirty days. An emulsion of D.D.T. applied to underwear has been found effective for two months in spite of eight trips to the laundry. In one prisoner of war camp, 77% of 252 men examined were lousy. Sixteen days after exposure to D.D.T. powder 171 were found to be louse free.

During early 1944 there was a relatively large outbreak of louse-borne epidemic typhus in Naples, which spread rapidly. Following dusting of 2,500,000 persons with D.D.T., the epidemic was stopped. Further-

more, no case of typhus has been reported in an American soldier in Italy.

Sprays of D.D.T. applied to walls remain lethal to flies for three months. The possibilities in prevention of enteric infection by this means are tremendous. Tests show that the preparation eradicates fleas from animals and gives long time protection against reinfestation. One application of a D.D.T. preparation gives 100% protection against bed bugs for at least 300 days.

In the field of agriculture, D.D.T. preparations are equally startling in their effects. They work both as contact and ingestational poison. They have been successfully used against the Japanese beetle, plant lice, codling moth, Colorado potato beetle, aphids, European corn borer and many other pests. Unfortunately, they also kill bees. Many entomologists state that this is the all time great in insecticidal development.

The potentialities of D.D.T. in preventive medicine and agriculture economics stagger the imagination.

ASHFORD BLAZES TRAIL

Meetings of doctors residing in the councillor districts of the State Medical Association have been held in previous years, but never has any conference as pretentious as that held at Ashford General Hospital, White Sulphur Springs, been attempted in this state. As a matter of fact, it probably marked the first time that any such meeting has ever been held at an Army General Hospital anywhere in the United States.

The conference attracted doctors from all over West Virginia. Many were present who had not attended a state meeting during the past several years. No one was disappointed. On the contrary, the program planned by the staff of the hospital was very interesting and instructive, and the ward rounds afforded visitors their first opportunity to observe the methods employed in the treatment of sick and wounded soldiers from the battle-fronts of the world. The success of the meeting might well mean that similar conferences will now be arranged in other Army General Hospitals.

Colonel Clyde M. Beck, the commanding officer, and the members of his staff, have contributed much of their time and talent to the development of programs for local medical societies in this state. For their willing cooperation in helping to make this meeting a success, particularly in the presentation of a scientific program of such outstanding worth, they have the sincere thanks of the 165 doctors who spent the week-end at White Sulphur Springs. Colonel Beck, a most genial host, personally contributed much to the pleasure and success of the occasion.

Much credit is due the district councillors, Dr. Andrew E. Amick and Dr. W. P. Bittinger, for initiating and developing the plan for a summer conference in a locality that has in the past meant so much, and which will undoubtedly continue to mean much to the members of the profession in this state.

ELMER NORVAL CARTER, M. D.

"Killed in action." How little do we appreciate the tragic significance of these fell words until their awful import is rudely dashed upon us by the fateful yellow telegram announcing that one near and dear to us in the armed forces has made the supreme sacrifice. "Killed in action." Tragic words! Awful words! Soul-crushing words when they refer to our own.

Captain Carter was born and reared in Huntington. After graduation in medicine and serving internship and residency, he located in his native city. Of a happy disposition, generous, energetic, resourceful, studious, and hard-working, he rapidly became one of the outstanding young physicians of that city, and enjoyed a large practice at the time he volunteered for service in the Medical Corps of the Army.

After training at Camp Pickett, he was ordered to England, where he was assigned to hospital work. Shortly afterwards, he was

promoted to a captaincy. As D-day approached, feeling that he could be of more service at the battle front, he asked for transfer to a combat unit and accordingly was assigned as a battalion surgeon to the Twenty-ninth Division. His last letter home, written on June 16th, described the horrors of modern warfare as the line surgeon sees them. Three days later he was killed in action.

Our heads are bowed in mourning because of his tragic death. He exemplified alike the unselfish spirit of medicine and that of the true physician. Regardless of personal danger, he heeded the call for service to his comrades and his country, and gave his own life that freedom might live. His spirit lives on and beckons us to a more earnest support of the war effort and to a better exemplification in our own lives of the ideal physician.

MORE THAN A GESTURE

One of the finest things that has ever been done by a component medical society in West Virginia came to light the middle of July in the form of a news release from the headquarters office of the State Medical Association. We refer to the action of the Harrison County Medical Society in waiving fees for services rendered and to be rendered the victims of the tornado which devastated part of the city of Shinnston on the evening of June 23. The decision of the members, which was unanimous, is in no sense an idle gesture. It is the sincere expression of the desire of these doctors to be of service to their fellowmen. The economic status of the injured is not inquired into. All are to be treated alike.

There has been nothing but commendation for the Harrison County doctors since the night of the disaster. Their response to the call for help was unanimous. Their skillful service was given without regard to personal comfort. They worked through the night and on into the next day. Several victims are still receiving care from these doctors and they will continue to have the best of medical and surgical attention so long as there is such need. All this without fees or the thought of fees.

All praise to the Harrison county doctors who by their actions have demonstrated again to the world that in times of necessity physicians are the first to seek the privilege of giving their best skill and knowledge to the work of alleviating suffering, without thought of personal gain.

STATE PRESS CONTINUES FIGHT

The State Sentinel, owned, edited and published at Fayetteville by J. Alfred Taylor, long prominent in public affairs, is another West Virginia paper out in front against socialized medicine. Speaking of a recent poll conducted by *Medical Economics*, the Sentinel reports that, "66% of the American people consider their physicians tops, both professionally and personally." Summarizing the results of the poll, The Sentinel continues:

"The good things said about the doctors summed up to what one might expect in an independent system of medicine where the success of a doctor depends upon his ability and character. They include pleasant manner, professional competence, thoroughness, promptness, friendliness, politeness, easy to talk to, sympathetic, helpful, cheerful, not pompous, etc.

"Contrast such a personalized medical service with socialized medical systems where the patient becomes a cog in an impersonal machine. The human relationship between the American doctor and his patient is one of the greatest assets of medicine. It should never be debauched by political tinkering."

The Times Advance, a weekly with a large circulation, published at Dunbar under the editorship of Cliff R. Mosier, defines socialized medicine as "a simple title of a very mixed up situation." Says the Times: "We regard the medical profession as one of the highest of human endeavors, by its very nature and traditions a most selfless and noble calling. We would not abate a jot or tittle of the criticism the doctors get, but we say let the doctors straighten themselves out. If we call in a politician to make doctors behave . . . .?"

According to this newspaper, a doctor feels public opinion and neighborhood criticism and he also competes with more liberal practitioners. If we cannot trust the members of this profession to remedy their own ills, whom can we trust, it is asked. "Socialized medicine is a complicated proposition," says the editorial. "The politicians are counting on the public being ignorant of the situation and too bored to listen to a competent analysis, but a vote to put another whip in the bureaucrats' hands won't settle the problem."

NECESSITY FOR PERIODIC EXAMINATION

In periodic health examination seems to be the possible solution of the cancer-prevention problem today—careful education in and search for factors indicating cancer, precancerous lesions, habits and disease which are known to predispose to cancer.

Cancer-control publicity should be so intensified and modernized as to reflect the definite opinion of authorities that much can be done which may prevent cancer of internal organs in the individual. The necessity for periodic examination by the physician naturally follows.

The physician must possess knowledge of the exciting factors and conditions known to precede the various forms of cancer. He must preach individual hygiene in this relation, and the importance of moderation in eating, drinking, exercise, and avoidance of exposure to all forms of irritation. Above all, he must inculcate the need for that godly quality, "cleanliness," the liberal use of soap and water, which is probably the best single preventive of preventable cancer.—Don D. Bowers, M.D., in *J. of the Indiana St. Med. Assn.*

NEW STRAINS OF MALARIA

New strains of malaria are being constantly brought back by our men from Guadalcanal, New Guinea and other South Pacific Islands. For example, one boy has had 18 relapses from malaria caused by a new virulent strain which we were prepared to control entirely satisfactorily.

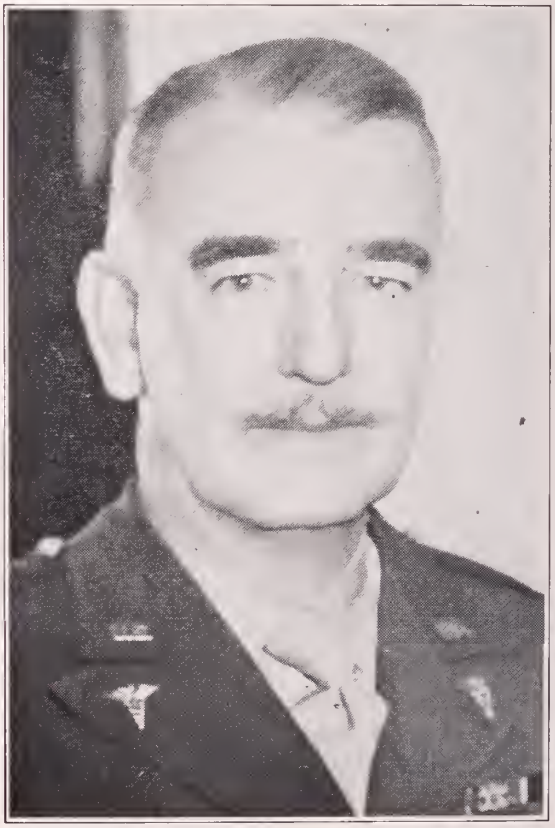
Even though at the present time malaria is well under control in the United States and more particularly in the South, we must not grow smug. We may have an explosion of malaria if we fail to progress along lines of its control.—Ernest Carroll Faust, M.D., as reported in *Int. Med. Dig.*, March, 1944.

General News

DOCTORS CROWD ASHFORD GENERAL FOR SIXTH DISTRICT CONFERENCE

The most interesting and largely attended summer conference ever held in any councillor district of the State Medical Association came to a close late Sunday evening, July 16, at Ashford General Hospital, White Sulphur Springs.

Through the courtesy of Col. Clyde M. Beck, Commanding officer, and the members of his staff, the 165 doctors who attended the annual conference of the Sixth Councillor District observed at first hand for two days the modern methods used in the treatment of sick and wounded soldiers at the institution. They explored every section of the hospital, talking with patients and listening attentively as members of the staff explained in detail the many things that are being done to restore the soldiers to good health and fit them for their return to duty or to civilian life.



Col. Clyde M. Beck, MC

All of the recreational facilities of the world famous Greenbrier, maintained by Ashford General for

the use of the thousands of soldiers treated there, were placed at the disposal of the guests.

Over a hundred doctors arrived in time for the opening of the conference, which had been arranged by the two district councillors, Drs. A. E. Amick and W. P. Bittinger, in cooperation with Colonel Beck. Following a luncheon at noon, an open meeting was held in the auditorium at which Colonel Beck delivered the address of welcome. From this point groups were organized for the various ward rounds, which were in charge of members of the staff who for the most part head the surgical and medical sections. So large was the attendance that in some instances doctors had to visit the clinics in relays.

Distinguished Visitors

The evening scientific program began at seven o'clock. Guests introduced included Lt. Ernest Childers, of Broken Arrow, Oklahoma, holder of the congressional medal of honor for "exceptional and outstanding service above and beyond the call of duty" while with the armed forces in Italy; Thomas J. Kehoe, assistant national service director of the Disabled American Veterans; and, Dr. Nearford Sakel, formerly of Vienna, now on the teaching staff at Columbia University.

Doctor Sakel, who was the guest of the Neuro-Psychiatric section at the hospital, is eminent in the field of neuro-psychiatry and is given credit for initiating and developing the use of insulin shock in the treatment of mental diseases.

Air Transportation of Wounded

Major General David W. Grant, Surgeon General of The Army Air Forces, appeared unexpectedly and was received with enthusiasm by a packed auditorium at the evening session. He reported that the Army Air Forces are now transporting 150 to 260 wounded soldiers per day from England to base hospitals in this country, and that it is expected that 5,000 soldiers will be returned by this method during the month of July.

Speaking of the miracles of air evacuation, he stated that since just before Pearl Harbor, 251,000 sick and wounded soldiers have been evacuated from battle zones and hospitals to points in this and other countries. Notwithstanding the high altitudes at which some of the planes were forced to fly, there have been but 11 deaths in transit. "We know of no type of case," said General Grant, "that cannot be transported safely by air."

The new Newton D. Baker General Hospital at Martinsburg was represented at the meeting by Col. D. H. Poer, Chief of Surgical Service, Major Carter H. Smith, Chief of Medical Service, and Major H. A. Swart, of Charleston, Chief of the Orthopedic Section.

Scientific Program

Lt. Col. John Pennock, Chief of Medical Service at Ashford General, presided at the scientific session Saturday evening. He presented a comprehensive paper on the clinical and pathological aspects of lupus erythematosus disseminatus. The cases at Ashford were thoroughly discussed by Colonel Pennock and by Major William A. Antopol, Chief of the Laboratory Section, from the standpoint of the most modern researches. Stress was placed upon the recent hypothesis of Klemperer and Baehr, giving to the connective tissue framework of the body new and important vital significance.

A paper on medical jaundice was presented by Major Milton L. Kramer, Chief of the General Medical Section. His remarks were prefaced by the statement that there are naturally no basic differences between this condition in soldiers and in the general civil population.

"However," he said, "occasionally the grouping and number of cases strongly bears out the present feeling that the so-called catarrhal jaundice or, as it is more recently termed, acute hepatitis, probably has a virus etiology.

"The variability of the clinical course is striking. Although it is well known that the pathological differences between acute yellow atrophy and catarrhal jaundice is merely one of degree, it is not so generally known that rapid death in a rare case or rapid recovery in the vast majority were not the only possibilities.

"Numerous patients may require months for complete recovery, and realization of this fact leads to more successful control and care. There is no doubt that the realization of this will prevent an appreciable number of these cases progressing to chronic liver disease with its largely irreversible set of accompaniments."

Neuro-Psychiatric Cases

The widespread incidence and importance of neuro-psychiatric diseases in the armed forces was discussed by Major E. N. Pleasants, Chief of the Neuro-Psychiatric Section, who stated that more than one-third of the rejections for the Army are for neuro-psychiatric reasons. He reported that malingering was rarely seen. Continuing, he said.

"In contrast to civilian mental hospitals where the psychoses are most often seen, in the Army the so-called borderline conditions prevail, the largest group being the psychoneuroses while the psychoses constitute the smallest. A neurologic disorder in the form of post-traumatic encephalopathy due to near shell or aerial bomb explosion is rapidly increasing without demonstrable gross organic change being present. The outlook is ultimately good in the majority of cases, but by no means can all be returned to duty.

"Approximately fifty per cent of the neuro-psychiatric patients at Ashford General have been returned to some type of duty.

"Experience in both the first World War and the present conflict has shown that the most favorable place for treatment is 'within sound of the guns' and that the recovery rate is in inverse ratio to the distance from the point of break-down to the point at which treatment is given. From 70 to 80 per cent of psychiatric disorders so treated have been returned to duty."

Filariasis

Filariasis was discussed by Major Ralph H. Kunstadter, Chief of the Communicable Disease Section, who told the doctors that this disease is prevalent throughout the sub-tropical and tropical regions of both hemispheres, particularly in many of the islands in the Southwest Pacific where unavoidable contact with infected natives and the infected host, the mosquito Culex Marginita, has caused some cases among our soldiers and sailors.

Speaking of the difference between filariasis and elephantiasis, Major Kunstadter said:

"Many people have considered filariasis and elephantiasis synonymous. However, elephantiasis is a late result of repeated reinfection and does not represent the early manifestations of the disease which, for the most part, include swollen glands and inflammation of the skin. These early manifestations disappear in a few days to a few weeks, and if the men are removed from areas of endemic infection early, the more severe complications do not occur, and complete recovery takes place. In other words, for a serious condition to develop in a given individual, exposure must be long and continued.

"The problem of control in this country is primarily that of control of mosquito hosts just as is the control of malaria, and public health officials will therefore take this problem seriously."

Discussing Penicillin Therapy, Captain F. W. Cooper, Jr., said:

Penicillin Therapy

"Penicillin to date has been used largely on badly infected wounds and injuries, and the results have been most favorable. Larger doses than are usually recommended have been found necessary in our experience. Of course there are a great many germ-caused diseases and germ-infected wounds upon which penicillin has no effect. Its greatest value to date has been found to be in streptococcus, staphylococcus, and gonococcus infections. Cure of gonorrhea in 24 hours with intensive treatment has occurred. The dread gas gangrene has shown some response to this drug when used in very large doses."

G-U Injuries of Warfare

Two cases of war-time genito-urinary injuries were discussed by Lt. Robert L. Anderson. He presented the method of management and their treatment at Ashford General. The first was a case of traumatic laceration of the urethra with subsequent obstruction due to scar formation, and the second a case of bladder stone forming around a piece of lead shrapnel.

Fractures of the Humerus

The subject of fractures of the humerus treated by the hanging cast was discussed by Captain James W. Riley. It was brought out that this method was not new but has been used with good results in the treatment of practically all types humeral fractures at Ashford General Hospital.

"After reduction of the fracture by manipulation," he said, "a hanging cast can be safely used for immobilization. With the elbow immobilized at right angles a plaster cast weighing from three to five pounds is applied from the knuckles to the upper arm. A cravat type sling about the neck and through a loop in the cast will act as a fulcrum from which the weight of the cast plus that of the arm will make traction on the humerus. Whether the top of the cast comes above or below the fracture makes little difference in the treatment of the fracture. Anterior angulation can be corrected by shortening the sling and posterior angulation by lengthening it. Following application of the cast x-rays should be made daily to check position of the fracture.

"Lateral bowing in lower third humeral fractures is a frequent deformity which results in limitation of extension of the forearm and of supination and pronation of the hand. The cause of this frequent deformity is failure to pronate the forearm when these fractures are immobilized.

Colles' Fracture

A technique of reduction and cast immobilization in the treatment of Colles' fracture was presented by Major Robert P. Kelly.

COLONEL E. C. JONES RETIRES

After 37 years' service in the Army, Col. E. C. Jones, Head of the Medical Department of the Fifth Service Command, Army Service Forces, at Ft. Hayes, Ohio, has retired from an active status. For the past four years Col. Jones has been connected with the Fifth Service Command, which is comprised of the states of Indiana, Kentucky, Ohio, and West Virginia.

Col. Jones has had the responsibility of organizing examining teams and medical facilities required for handling the mobilization of inductees, and has aided materially in the work of the procurement and assignment service. In addition, eight general hospitals in the Fifth Service Command have been equipped and staffed under his supervision. He has visited West Virginia several times during his service at Ft. Hayes, and has attended several meetings of the state Procurement and Assignment Committee.

Col. Edgar A. Noyes, MC, commanding officer of the Cushing General Hospital at Framingham, Massachusetts, succeeds Col. Jones as head of the Medical Department at Fort Hayes.

NUTRITION CONSULTANT APPOINTED

Miss Evelyn Yokum Fortney, vocational home economics teacher at the Shinnston High School for the past five years, has been appointed nutrition consultant in the division of maternal and child hygiene of the state Health Department.

DOCTORS WAIVE FEES FOR SERVICES TO VICTIMS OF SHINNSTON DISASTER

At a meeting of the Harrison County Medical Society, held at Clarksburg July 7, it was unanimously agreed that no charge is to be made for services rendered by the members in connection with the disastrous tornado which swept through the Shinnston area June 23, leaving a death toll of 70 in that community alone and sending scores of injured to hospitals. The members waived not only fees for services at the time of the disaster, but also fees for medical and surgical care that may be necessary until the injured have recovered.

The society is composed of 85 doctors, 20 of whom are serving in the armed forces.

First Aid Station Set Up

On the night of the disaster, an emergency first aid station was set up in the Methodist church at Shinnston by Dr. Harry V. Thomas, of Clarksburg, chairman of the medical unit of the Red Cross disaster committee. Doctors and nurses recruited in Harrison and Marion counties responded quickly to the call and worked in shifts during the night and far into the following day. The tornado which struck shortly before 9 P. M. paralyzed electric power systems, and doctors resorted to candles, lanterns, flares, and battery-lighting appliances for light in administering to the injured people on the ground and at the hospitals in Clarksburg.

Quick Response to Call

Cots and medical supplies in abundance were quickly placed at the disposal of the relief forces. Every available ambulance in the Clarksburg-Shinnston-Fairmont area was pressed into service. Doctor Thomas expressed the opinion that the quick response of doctors and nurses, volunteer first-aid workers, municipal and county officers, state troopers and members of the national guard, enabled victims to obtain prompt medical and surgical care that no doubt resulted in the saving of many lives.

The druggists of Central West Virginia contributed much to the effectiveness of the work by placing their full facilities at the disposal of doctors in the affected area.

Doctors located in nearby parts of West Virginia which felt the force of the tornado, particularly those in Taylor, Tucker, Barbour and Randolph counties, did outstanding work in treating injured persons rushed to hospitals and first-aid stations. Doctors in practically every section of the state stood by during the night, prepared to go to the aid of the doctors in the central part of the state if their services should be needed.

200 Doctors Cooperating

Doctor Courtney Smith, Red Cross Medical Director, reports that the victims of the tornado were cared for in 22 hospitals in West Virginia and Pennsylvania and that approximately 200 doctors were cooperating in the relief program.

Members of the Red Cross nursing staff, student nurses, and nurses' aides worked side by side with nurses from the hospitals and those recruited from registers in several West Virginia cities. Doctor Thomas has stated that so eager were they to lend their services that some worked for more than 24 hours without relief.

EMS UNIT SET UP IN CHARLESTON

The following Charleston doctors have been commissioned by the USPHS as officers in the reserve corps to serve as members of the Charleston affiliated unit:

Archer A. Wilson, chief of surgical services and unit director; John E. Cannady, Earl M. Peck, and E. A. Litsinger, general surgery; Randolph L. Anderson and George Miyakawa, orthopedic surgery; Thomas G. Reed, urology; Walter Putschar, pathology; W. Paul Elkin, radiology; T. Maxfield Barber, chief of medical services; George P. Heffner, internist; Herbert M. Beddow and Daniel N. Barber, general medicine; and John J. Herlihy, dental surgery.

Two Charleston hospitals, Charleston General and St. Francis, serve the unit, which is set up under the emergency medical service in cooperation with the medical division of the OCD. Members of the unit will be called into active service only to furnish care for patients of the emergency medical service or to render temporary assistance to the Army in the emergency care of military personnel.

WEST VIRGINIA NURSES TO MEET

The annual meeting of the West Virginia State Nurses' Association will be held at the Windsor Hotel, Wheeling, October 26-28, 1944. No meeting was held in 1943. Miss Madge L. Duncan, of Clarksburg, is president of the association, and Miss May Maloney, of Charleston, executive secretary. Mrs. Grace L. Dick, of Wellsburg, is chairman of the committee on general arrangements.

ACS HONORS NITRO VISCOSE PLANT

The American College of Surgeons has awarded a certificate of approval to the Nitro plant of the American Viscose Corporation. This certificate is granted to an industrial establishment only in cases where its medical organization and service are fully approved and where there is assurance that there will be continued compliance with the College's minimum standards for medical service in industry.

The Minimum Standard for Medical Service in Industry was formulated by the American College of Surgeons in 1931 following several years' study by a committee composed of representatives of the College of Surgeons, medical departments of insurance companies, and other industrial organizations.

Acceptance and maintenance of the standards established by the College are voluntary on the part of an industrial establishment. The medical department of such an establishment is charged with the prevention and treatment of illness among employees.

At Nitro, The American Viscose dispensary, in charge of Dr. C. N. Scott, is fully equipped to aid employees in any emergency. There are emergency, examining, laboratory, operating, x-ray, and treatment rooms, a nurses' room and a waiting room for the patients.

MUST REPORT DEMEROL ON HAND

All doctors in West Virginia who hold narcotic licenses are required to file immediately an inventory showing whether or not they had any isonipecaine, or demerol, on hand July 1. Forms for the purpose have been mailed to all registrants, and they are instructed to affix to all packages of demerol on hand labels bearing the words "In stock—inventory, July 1, 1944," followed by the name or initials of the owner. The reports must be sworn to and mailed to the Collector of Internal Revenue at Parkersburg.

Demerol on hand in a registrant's stock July 1, 1944, which has been properly inventoried and labeled, may be sold without affixing tax stamps. Sales made subsequent to the effective date of the act are required to be made pursuant to an official narcotic order form or physician's prescription in the same manner as morphine, regardless of whether the package is tax-stamped or merely bears the proper label.

CHANGES IN HEALTH OFFICERS

Dr. James A. Dolce, Health Commissioner at Wilmington, Delaware, has accepted appointment as county health officer at Fairmont, succeeding Dr. J. W. Davis who resigned to join the staff of the city health department at Baltimore. Dr. Dolce was formerly connected with the USPHS aand engaged in public health work in Michigan for several years before going to Wilmington.

Dr. Herbert Duncan, Health Officer for District No. 2, at Lewisburg, has resigned to accept a residency in eye, ear, nose, and throat at the Nashville General Hospital, Nashville, Tennessee. His successor has not yet been appointed.

Dr. Albert M. Price, Kanawha County Health Officer, with headquarters at Charleston, has resigned effective August 1 for the purpose of engaging in private practice. Dr. Price was formerly director of the division of communicable diseases in the state health department.

Dr. Walter J. Riley, Health Officer for District No. 1, at Weston, has been given an indefinite leave of absence on account of ill health.

PHARMACISTS OPPOSE WAGNER BILL

At the War Conference of the West Virginia State Pharmaceutical Association, held at Fairmont, in June, the members unanimously adopted a resolution in opposition to any form of socialized medicine. Stating it as their opinion that governmental regimentation of medical practices and health services are contrary to the best interests of the citizens of the United States, the Association went on record as opposing the Wagner-Murray-Dingell bill "or any other similar legislative proposals which include autocratic principals for the governmental regimentation of medical practices and health services."

ADVISORY COMMITTEE NAMED

A new five-member advisory committee, composed of directors of the various bureaus, has been set up in the state health department by Dr. J. E. Offner, State Health Commissioner. Members, who were selected on the basis of seniority, will consider personnel problems, inter-divisional relationships, departmental morale and merit system qualifications in the state health department.

The committee is composed of J. B. Harrington, Miss Katherine Cox, Miss Laurine C. Fisher, Dr. N. G. Angstadt, and Dr. C. S. McKinley.

CLARKSBURG HOSPITALS WAIVE FEES

The two Clarksburg hospitals to which most of the victims of the Shinnston tornado were taken have waived all fees in connection with their services, according to information received at the headquarters offices of the State Medical Association as this issue of The Journal goes to press.

These hospitals, St. Mary's and Union Protestant, will make no charge for rooms used or to be used. Neither will charge be made for any of the usual services, including x-ray and laboratory. This policy will be pursued regardless of the economic status of those who were hospitalized as a result of injuries sustained at the time of the disaster, and is in line with the decision of the members of the Harrison County Medical Society to waive all fees for medical services rendered and to be rendered the victims of the tornado.

DAR URGES DEFEAT OF TWO BILLS

At the last continental congress of the Daughters of the American Revolution, held in New York City, a firm stand was taken by the members against socialized medicine and the regimentation of science in the field of technical invention. The following resolution was adopted at this meeting:

"*Resolved*, That the National Society, Daughters of the American Revolution urge the Representatives in Congress to take active opposition to all legislative measures that have for their purpose the regimentation of science in the field of technical invention and in medicine, specifically (1) the Kilgore Bill S702 which proposes government control of technical research and patentable inventions, and (2) the Wagner Bill S1161 which would provide for the socialization of medicine, doctor's fees, and hospital care for the entire nation, under the direct control of the Surgeon General of the United States."

HEALTH INVENTORY SHOULD BE COMPLETE

Health inventory includes as essential elements study of the past history of the individual (it must be remembered that we are today because of what we went through yesterday) a clinical physical examination, certain laboratory and x-ray studies, and investigations into certain functional reserves. Not until all these data are available can a usefully accurate appraisal be made of the state of health or the approximate physiological age.

No business man expects an inventory or annual audit of the state of his business to be accomplished in a few minutes. Nevertheless, it is all too frequent that senescent individuals, laboring under great stress and tension will ask the doctor, "Listen to my heart, Doc, and tell me how I am today." This cannot be done.—Ed. J. Stieglitz, M.D., in *Med. Annals of the District of Columbia.*

Book Reviews

NEW AND NONOFFICIAL REMEDIES, 1944—Contains descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1944. Cloth. Price, postpaid, $1.50. Pp. 778. Chicago: American Medical Association, 1944.

The current volume of New and Nonofficial Remedies reflects two important and forward looking decisions of the Council, namely, to use the metric system exclusively in all its publications, and to consider for acceptance contraceptive preparations offered for use as prescribed by physicians. These decisions in turn reflect the vigorous and progressive leadership of the Council in the service of Medicine.

The chapter on contraceptives is quite comprehensive; with the acceptance of more preparations, it will undoubtedly assume a large place in New and Nonofficial Remedies. The Council has thus far accepted some contraceptive jellies and creams, contraceptive diaphragms, diaphragm inserts, syringe applicators, and fitting rings. It is understood that a number of additional preparations have been submitted for Council consideration since the book went to press. This chapter represents a courageous and long-needed innovation.

Some of the new preparations that appear in this volume are: Succinylsulfathiazole, a new sulfonamide, a proprietary brand being "Sulfasuxidine"; Diodrast Concentrated Solution, a preparation of the already accepted Diodrast, for use in special diagnostic procedure for visualization of the circulatory system and also cholangiography; a preparation of Sodium Benzoate for use as a liver function test; Mersalyl and Theophylline, accepted under the name Salygran-Theophylline Tazlets, proposed as an adjunct to intravenous injection of the already accepted drug; Zinc Insulin Crystals and Zinc Insulin Injection Crystalline; Tetanus Toxoid; and Concentrated Olevitamin A and D, a dosage of the pharmacopoeial preparation.

Several general articles have been revised to bring them up to date. More or less important revisions have been made of the following chapters: Barbituric Acid Derivatives, Estrogenic Substances; Parathyroid; Ovaries; Sulfonamide Compounds; and Vitamins, especially the sections, Vitamin B Complex and Vitamin D.

One of the really outstanding advances is the all-out adoption of the metric system, a long needed

reform. While this will work something of a hardship on the older generation of physicians, and while in actual practice a long time will elapse before all prescriptions will be written in the metric system, certainly that is the ideal to be used as an objective.

This volume retains the attractive green binding and the same general format as the one preceding. It contains so much information about the recent drugs we use in everyday practice as to make it of paramount interest to all those concerned with rational and modern drug therapy.

TROPICAL NURSING—A. L. Gregg, M.D., M.Ch., D.T.M. & H. Lond., Member of Associate Staff at the Hospital for Tropical Diseases in London, and lecturer on Tropical Diseases in the Westminster Hospital Medical School in England. New York: Philosophical Library, Inc., $3.00.

There are many books on nursing and some aspects of nursing are the same whether in the tropics or elsewhere. Yet the nurse who has not understood the difference between the conditions of everyday life in tropical countries and those in a temperate climate will find much of her work and knowledge nullified.

In these days especially she may be called upon in remote districts, having no doctor within many miles, to deal with and even diagnose diseases which she has never had a chance to study in the course of her training, such as Beriberi or Blackwater Fever.

For this purpose in particular, of giving the nurse this required mental equipment which she needs, has this book been written.

Added value has been given to this book by inclusion of a special section devoted to personal hygiene in the tropics. In brining health to others the first essential is that a nurse shall herself be healthy, and a careful study of this section will go far towards safeguarding her from the many pitfalls into which she can so easily stumble in unhygienic tropical countries.

Finally, there is a glossary which should prove not the least useful of the contents of this unusual book.

The size of the book is handy, slightly smaller than the Readers' Digest format.

MINOR SURGERY—Edited by Humphry Rolleston and Alan Moncrieff. New York: Philosophical Library, Inc., 174 pp. 30 illustrations. $5.00

Reviewed by R. J. Kent, M.D.

This volume is composed of eighteen articles by individual writers, covering only problems of actual minor surgery, including the fields of eye, ear, nose and throat, gynocology and pediatrics, as well as such aspects of anesthesia and analgesia as come within the book's range. With eight, the number of pages alloted for each chapter, the variety of everyday problems treated is surprising in their scope and quality though by necessity in many instances the discourse is more of a warning than actual instruction. Only basic matters, procedures and "don'ts" have been written up in a precise and to the point manner, mostly without discussion of alternative ways of treatment. Only modern and proven means of dealing with these cases are presented. The added illustrations fit well into the general plan and a comprehensive index is most helpful.

TECHNIQUE IN TRAUMA—Fraser B. Gurd, M.D., C.M., and F. Douglas Ackman, M.D., C.M. From the Montreal General Hospital and McGill University. Philadelphia: J. B. Lippincott Company. 68 pp. Illustrated.

Reviewed by R. J. Kent, M.D.

A short summary of this volume is given in the initial lines of the Commentary: "The authors have described a plan for treating burns by preliminary cleansing, sulfathiazole emulsion and occlusive pressure dressing with infrequent change. With respect to wounds they recommend treatment by surgical operation, followed by the establishment of 'certain drainage' and plaster encasement."

The plan of treatment is presented in precise detail and is built on the use of a newly developed bacteriostatis as supplied by five percent sulfathiazole in an emulsion which by its preparation provides an exceptionally high percentage of sulfathiazole in molecular solution readily available to, and penetrating, the tissues. As a remarkable feature, it is claimed, and these claims supported by data, that despite liberal application of this emulsion over large body surfaces, the concentration of sulfathiazole in the blood never was found exceeding 3.5 mgm%. With this emulsion as a reliable bacteriostatic, emphasis is placed upon the advisable use of pressure dressings, occluding the wound surfaces and preventing contamination and secondary infection to omit the necessity for frequent changes of the dressing. All the other essentials in the proper management of burns, such as treatment of shock, requirements for surgical procedures, etc., have found full considerations. The other important feature stressed by the authors is the timing of the

successive steps along the course of treatment, with particular emphasis on grafting at the proper time to prevent scar formation which is prone to occur even under epithelialized surfaces when grafting is done on well developed granulation tissue.

Based upon the experience collected over several years, the procedure has been worked out in every detail. It is therefore particularly regrettable that due to war time restrictions, penicillin is not included in this work which is well illustrated and has inserted several charts covering the important features of the book.

THE PANEL SYSTEM IN ENGLAND

"I am very proud of my professional liaisons here. The upper crust of British medicine is fully equal to ours, though the general average may not be quite as high.

"Incidentally, I have never met an English man or woman who is a member of a panel. My secretary, who is typing this letter, does not even know what it means. The panel system, apparently, is that in which a few poor-salaried doctors take care of a large practice of indigent and ignorant patients.

"You insult any Englishman by asking him if he belongs to a panel. Beveridge or no Beveridge, this country is going to practice private medicine after the war, and up to now, if we admit that compensation work is 'state medicine' at home, England has less state medicine than the United States. Intelligent people in Great Britain insist upon selecting their physicians, and always will."

The writer of the above, whose name we omit for military reasons, is no casual or fly-by-night observer, but a Rocky Mountain physician of highest attainments, who has known Britain in peace and through two wars. We prefer his word over that of some of our professional uplifters in Washington who would have us believe that for Englishmen generally the sun rises and sets in the so-called panel system of politically managed health insurance.—*N. Y. State J. of Med.*

USE OF RESUSCITATORS

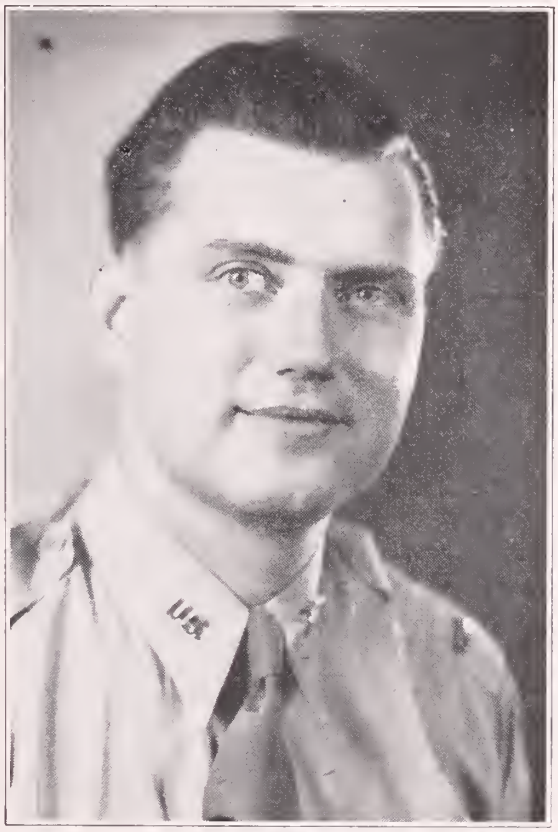
A warning has been issued against use of "resuscitators" for victims of carbon monoxide poisoning or other asphyxia. Prof. Y. Hendersch, of Yale University, believes that there is danger of injury to lung tissue. The Schafer prone-pressure method is now used by the Navy.—*R. N.*

Obituraries

CAPT. ELMER NORVAL CARTER, MC

Captain Elmer Norval Carter, MC, AUS, was killed in action in Normandy June 19, while serving as a battalion surgeon in the Twenty-ninth Division.

Born in Huntington, October 17, 1911, Captain Carter was the only son of Eustace and Sappho Bryan Carter. His father served as a sergeant in the American Army in the Philippines just subsequent to the Spanish-American War. His mother was the daughter of the late Dr. William Pinkney Bryan who practiced medicine for more than fifty years in Cabell and Mason Counties, much of that time in Guyandotte.



Capt. Elmer Norval Carter, MC

Norval, as he was familiarly known to his friends, attended the public schools of Huntington, graduating from Central High School in 1930. His pre-medical college work was done one year at Marshall College, one year at West Virginia University, and one year at the University of Ala-

bama. He received his M.D. degree from the Medical College of Virginia in 1937. The next year he served an internship at the Scott-White Clinic, Temple, Texas, after which he engaged in private practice for one year at Timson, Texas. The next year he served a residency in psychiatry at Spencer State Hospital, and the year following a residency in medicine at the Chesapeake and Ohio Hospital, Huntington. Upon the completion of this residency, he entered private practice in association with the late Dr. Paul D. Hayman, and soon developed a large clientele.

Dr. Carter volunteered for service in the Army Medical Corps in July, 1942, and trained at Camp Pickett, Virginia. In 1943, he was ordered to England where he was assigned to hospital duty. Shortly after landing there he was promoted to a captaincy. As D-day approached, Captain Carter, feeling that he could be of more service with troops in action, applied for transfer to a combat unit and was assigned to the Twenty-ninth Division, one of the first to land upon the Normandy beachhead.

Besides his parents, Dr. Carter leaves his widow, Mrs. Emma Fern Lowry Carter, and two sons, Thomas Eustace, age seven, and Walter Ford, four. He was a member of the Methodist Church, Phi Beta Pi Medical Fraternity, West Virginia State Medical Association, and the American Medical Association.

CARLOS ALONZO GOOCH, M.D.

Dr. Carlos Alonzo Gooch, 69, of Scarbro died of a heart attack in a hospital at Oak Hill, July 14, 1944.

Dr. Gooch was a member of the Oak Hill Baptist Church and the Knights of Pythias. He was formerly a member of the American Medical Association and the West Virginia State Medical Association.

SEDATIVES FOR SEAMEN

To help quiet the convoy-worn nerves of American merchant seamen, the Medical and Surgical Relief Committee of America has donated to the War Shipping Administration 4,000 capsules of sedatives requested for use in recuperation centers in England and North Africa, according to a report by Dr. Joseph P. Hoguet, medical director of the Committee.—*Minnesota Medicine*

County Society News

FAYETTE

At the regular monthly meeting of the Fayette County Medical Society, held at the Hotel Hill, Oak Hill, July 11, two interesting papers were presented.

Dr. J. N. Reeves discussed the subject of "Abnormalities of the Diaphragm and Their Treatment," and Dr. J. B. Thompson spoke on the "Diagnosis of Diabetes Mellitus."

E. S. CARTER, JR., M. D.
Secretary.

DOCTORS SEEK FRIENDLY COMMUNITIES

Medicine has been criticised because of the uneven distribution of doctors. The same criticism applies to other necessities of life such as sunshine and rain. No one has been able to do anything about the weather, but we can do something about the doctor.

Doctors are human and they go where they think they are wanted and where there are satisfactory living conditions for their families. Any community that is without a doctor can get one (in normal times) if they show enough interest. a well-equipped office and a nice home would land many a man just starting out in his career, and possibly some who have made a poor start. Such a procedure would be less costly than establishing "Mayo Clinics" at every cross roads. Besides it would more nearly fit the needs and would require no legislative enactments.—*Va. Med. Monthly.*

WHAT YOU SHOULD KNOW ABOUT TB

A completely rewritten edition of the booklet for laymen, "What You Should Know About Tuberculosis," has been published by the National Tuberculosis Association. Nontechnical in character, the publication is intended for the sanatorium patient and his family. Copies may be obtained from state or local tuberculosis associations.

ONE SPUR CAVALRYMEN

I have heard that Scotch cavalrymen wear only one spur. Why is that?

They figure if one side of a horse advances, the other side is certain to do likewise.—*The War Doctor*

WITH DOCTORS IN THE SERVICE

Lt. Col. Bert Bradford and Lieutenant Glen F. Palmer, of Charleston, are in the same outfit with the invasion forces in France. A son, the third, was born to Mrs. Bradford at a hospital in Charleston July 19. The other two boys are aged, respectively, eight and four.

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Captain James S. Klumpp (MC), USNR, of Huntington, has been transferred from the Naval Air Station at Miami, Florida, to the U. S. Naval Convalescence Hospital at Yosemite, California.

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Dr. Jack T. Gocke, of Clarksburg, is stationed at Camp Stewart, Savannah, Georgia. He was recently promoted to the rank of Captain.

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Lt. Comdr. John Lutz (MC), USNR, of Charleston, who has been visiting friends and relatives in Charleston, is now back on shipboard somewhere in the Pacific.

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Dr. Henry Lester Margolis of Montgomery, who has been on the teaching staff at Duke University Medical School, at Durham, North Carolina, has been called to active duty as a First Lieutenant in the Army Medical Corps.

Lt. Comdr. John Lutz (MC), USNR

Lieut. H. E. Muller (MC), USN, of Huntington, who has been stationed at Cherry Point, N. C., is now assigned to the M.A.G. 52, 9th MAW, MCAAF, Congaree, Columbia, South Carolina.

* * * *

Captain Clinton B. Chandler, of Iaeger, is now assigned to the 132nd Station Hospital at Pomona Ordnance Depot, Pomona, California.

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Dr. John N. Marquis (MC) USNR, who has been stationed in the Southwest Pacific for several months, is now with the Bureau of Medicine and Surgery, Navy Department, Washington. He was recently promoted to the rank of Lieutenant Commander.

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Major Lewis E. Nolan, of Montgomery, who is chief of the laboratory service at the Station Hospital at Fort Sill, Oklahoma, has sent us a copy of the Fort Sill Army News in which several pictures taken in his laboratory are reproduced. Incidentally, this paper, an eight-page weekly, was awarded second place in the printed division of the 1944 University of Missouri School of Journalism national contest for service publications.

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Captain Otis E. King, of Bluefield, has been transferred from the Station Hospital at Eustis, Virginia, to the Woodrow Wilson General Hospital at Staunton.

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Captain T. L. Woodford, of Belington, is assigned to a transport plane which is evacuating wounded soldiers from the Normandy front to base hospitals in England.

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Captain Junior W. Myers, of Philippi, is in charge of the E.E.N.T. unit at the Station Hospital at Camp Marianna, Florida. He was visiting relatives at Philippi June 24 when a tornado struck the central part of the state with such devastating force, and assisted local physicians in administering to the needs of the victims in that area.

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Lieut. Franklin B. Murphy, of Philippi, who has been in North Africa for several months, is now stationed in Italy.

LIBRARY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA

The following letter from Captain John C. Condry, of Charleston, is the first to be received from a West Virginia doctor assigned to duty with the invasion forces

Dear Mr. Lively: 7 July 1944.

I have been on the go since coming to England. From a very peaceful and serene life in Ireland, I found myself on the coast of France on D-day, right in the middle of the "big show." I was assigned to an L. S. T. during the early assault phase of the invasion. At this time these ships were used to transport casualties back to England. We were adequately equipped with an operating room and facilities for handling two hundred casualties. There was plenty of surgery to do on the first trip, but very little after that. As you see, I have been transferred from my old unit to a field hospital.

Sincerely, John.

* * * *

Captain E. H. Mann, of Philippi, is with our armed forces somewhere in New Guinea.

* * * *

Lieut. Comdr. Bruce H. Pollock (MC), USNR, of Charleston, writes from somewhere in the Pacific, reporting the organization of what is probably the first American medical society on former Japanese soil. His letter follows:

23 June 1944.

Dear Mr. Lively:

Have just received the May issue of The Journal, the second one I have seen in many months. Dr. Angelo J. Villani, of Welch, gave me a copy a month or so ago. I deeply appreciate it. Besides the scientific articles, it brings you a little closer to the friends you have in the medical profession back home. I hope that you had a good meeting at Wheeling and only wish that I could have been with you.

I have been overseas now almost ten months and have had a chance to observe the various tropical diseases. I spent four months on one island in the South Pacific, and then moved up to the Central Pacific, where I have been ever since.

Dr. John Hangen, of Minneapolis, and I have set up a small, modern hospital in an old Japanese building, formerly a power house. We have made extensive improvements with cement, wood and water pipes. We have to date done 160 operations of all kinds. We have had no wounded since February, at which time we were heavily bombed by the enemy. Our sector has been very quiet since then.

There are enough doctors on this island to start a medical society. So far as I know, this is the first American medical society to have been organized on former Japanese soil. Meetings are held bi-monthly and scientific papers are read. Dr. Villani and I are the only West Virginia doctors here. He is chairman of the entertainment committee, and I was elected president. We have 28 members.

The principal diseases that we have seen include yaws, leprosy, filariasis, dengue, malaria and typhus. With the exception of yaws and leprosy, our command has had many cases of each of the other diseases.

Our climate is hot and humid, though we have had cool weather at night due to the fact that we are close to the ocean. There are no trees. There used to be shrubbery and great numbers of coconut, but Naval gunfire made shambles out of all vegetation here.

Thank you again for the copies of The Journal, and the best of luck to you all.

Sincerely, Bruce H. Pollock.

Lt. A. J. Villani (MC), USNR

Commander Berlin B. Nicholson (MC), USNR, of Parkersburg, who has been stationed at Camp Peary at Williamsburg, has been transferred to the Naval Hospital at Portsmouth, Virginia.

* * * *

E. P. Wells, of Charleston, formerly secretary of the West Virginia Tuberculosis and Health Association, is now serving as a pharmacist mate, third class, at the U. S. Naval Hospital, Great Lakes, Illinois. He writes that the work he is doing is interesting. "We are studying practically everything but obstetrics," he says, "but it is all very interesting and makes me feel that my efforts in the war may be of some value after all."

* * * *

Captain Elmer E. Myers, of Philippi, is now stationed somewhere in India.

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The following letter from Lt. Comdr. L. B. Gang (MC), USNR, of Huntington was received July 20:

China, June 1. 1944.

Dear Mr. Lively:

Thank you for your letter of March 24, which just reached me. I hope the convention at Wheeling was a real success.

The censorship in these parts is of necessity a bit more strict than in other theaters of war. I am not permitted to write anything about my work. You were right when you stated that I have a most interesting story to tell, but unfortunately it will have to wait unil I leave China. However, I believe I may reveal several incidens.

In one village I saw a youth of about twenty lying on a mat in the market place, suffering from abdominal colic. By pushing my way through a dozen rows of onlookers, I managed to watch a Chinese "doctor" stick three long needles into the boy's abdomen. Each needle had a different ornament at the head end, and each was placed in an appropriate location in the abdomen. After a few moments the needles were withdrawn and the patient was left lying there, writhing in agony. He was still there an hour later. There was no sterilization, of course. Quite the opposite.

In that same village, one of our group killed a snake. We didn't realize that snakes were sacred. That day we had a very heavy rain, and a flash flood resulted. We learned that this was being blamed on the foreigners who killed the snake, and all over town good Chinese folk were burning incense in an effort to counteract our evil influence.

Among other things I've learned recently is that powdered frog is prescribed for syphilis, and that a Chinese doctor can look in the eyes of a man bitten by a dog and foretell whether he will develop rabies. The latter does away with the necessity of observing the dog or examining his brain. I've also learned that scabies and trachoma are so common in China that many fairly intelligent persons do not consider them diseases.

Of course, when I speak of Chinese doctors, I am not referring to those educated in modern medical schools and practicing Western medicine. There are far too few of the latter.

With kindest regards, I am.

Sincerely, L. B. Gang.

PHARMACISTS PAID TRIBUTE BY UPJOHN

Pharmacists are performing herculean tasks in the armed services of our country and in civilian business. To pay tribute to these men, The Upjohn Company is featuring "Pharmacy in the War" in their new institutional window display.

The large center piece of the display carries a number of official Army and Navy photographs showing pharmacists on duty in various parts of the world, including such areas as Italy, Australia, and Bougainville. Prominence is given to the statement: "From foxholes to base hospitals . . . from jungles to Arctic wastes . . . pharmacists are serving the armed forces."

One large side card carries photographs showing research, production, and packaging processes in the manufacture of pharmaceuticals. The other side card shows some of the new pharmaceutical products that are performing such miracles on the battlefront. One of the cards bears this startling assertion.

> Average consumption of pharmaceuticals of men overseas is two pounds per man per month.

Pharmacists are serving in every branch of our armed forces. They are contributing much to the war effort on the home front by carrying on under discouraging handicaps of manpower shortage. They are helping the physicians carry their heavy loads under wartime conditions.

The people in every neighborhood should know these facts. This Upjohn display will tell them.

TANTALUM SOON AVAILABLE TO SURGEONS

Tantalum plates, foil, screws and wire to repair broken bones, nerves and skulls will shortly be available to civilian surgeons through a recent allocation of the War Production Board, according to an announcement made by Dr. Gustav S. Mathey, President of the Johnson & Johnson Research Foundation, New Brunswick, New Jersey.

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The Johnson & Johnson Research Foundation is a non-profit organization, founded in 1940 to endow research in universities and hospitals and to disseminate summaries of findings to members of the medical profession. Dr. Mathey states that by an agreement between the Ethicon Suture Laboratories, Johnson & Johnson subsidiary, and the Fansteel Metallurgical Corporation of North Chicago, the availability of tantalum for civilian surgeons is assured at an early date.

Tantalum has assisted surgeons to return to active life many cases which in the last war would have been disfigured and incapacitated for life. Lost portions of the skull, ears, noses and other parts of the face are being replaced with tantalum. One veteran has a tantalum "belly wall." Nerves which control motion in arms and legs are stitched with tantalum thread and protected while healing with tantalum cuffs. Facial paralysis is relieved by small, saddle-shaped pieces of tantalum and wire used to pull the corners of the mouth to a normal position. This stops the unpleasant drooling and facial distortion which go with the condition. Cleft plates also are being corrected.

HOSPITAL ADMINISTRATORS' INSTITUTE

Conducted for the first time in its 12-year history by the American College of Hospital Administrators, the Chicago Institute for Hospital Administration will be held at International House at the University of Chicago, September 11 to 22. Formerly sponsored by the American Hospital Association, the institute will be under direction of Dr. Malcolm T. MacEachern, Chicago, who has been its director since its inception.

There will be lectures in the forenoons, seminars and field trips afternoons to selected Chicago hospitals for demonstrations, and evenings will be devoted to conferences on administrative and departmental problems facing hospitals.

Registration will be limited to 100 hospital administrators and assistant administrators. Applications for registration may be made through Dean Conley, executive secretary of the American College of Hospital Administrators, 18 East Division, Chicago.

VALUE OF SLEEP

The physician has a daily demonstration of the almost magic effect of sleep and values it highly as a prime essential in man's physical and mental well-being. Sleep is the state in which healing and recuperation proceed at their highest rate, and during the period of growth it provides opportunity for this process to go on simultaneously with recuperation which makes up for the wear and tear of the day's activities.

Plants and animals require sleep for their growth and development. Knowing all of this, the physician himself often neglects to put into use this valuable theapeutic aid, although he strongly advises his patients as to its absolute necessity. Unfortunately the physician does not always practice all he preaches, even though he is convinced of the great healing powers that lie in the procedures he so

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The true physician thinks first of his patient's needs and the service he can render in meeting these needs. This is often knowingly done at the sacrifice of his own interests and health, but that is the price which the sons of Aesculapius willingly pay in the practice of their noble profession.—*J. Med. Soc. of N. J.*

HUNGER GREATEST FACTOR IN DISEASE

"In some countries the average death age has fallen by more than ten years. In many countries a second pregnancy is tantamount to suicide. And everywhere disease is appallingly on the increase, while the means to fight it are utterly insufficient. It is not solely a question of drugs and hospitals and medical supplies, though these are of vital importance. Hunger is the greatest factor in diseases, and hunger for more than half a billion people—perhaps for one-fourth of the earth's population—is today the great fact of life."—Herbert H. Lehman, director general of the United Nations Relief and Rehabilitation Administration, in *New York Times Magazine.*

DYSPEPSIA IN WORLD WAR II

In the war of 1914-1918 disorders of the digestive tract during and after the period of mobilization did not loom as important. Today such diseases are the most important medical problem of the war and dyspepsia represents the single most important prevalent type of disease among hospitalized military patients. Almost without exception contemporary writers convey the impression that the high incidence of gastric and duodenal ulcer has been a development since 1918.

It is a safe rule to suspect every sick person who has recently returned from a malarial country of having malaria, even in the absence of a history of previous attacks, aenemia and enlarged spleen, unless some other diagnosis is obvious.—*Proc. Staff Meetings of The Mayo Clinic.*

TOXICITY OF SULFADIAZINE

Perrin Long has recently stated that the frequency of toxic reactions following sulfadiazine is only 6.5 per cent as compared to 11.9 per cent following sulfanilamide, 15.9 per cent following sulfapyridine and 18.6 per cent following sulfathia-

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zole. We must wait for more extensive clinical use of sulfamerazine and other new sulfa drugs before their toxicity can be determined as satisfactorily as these first four.—*International Med. Dig.*

MINORITIES ESSENTIAL

Unity is of prime importance in the Medical profession today. Unity implies a willingness on the part of minorities to abide by majority decisions until such a time as they are able to prove their points and in turn become the majority. Minorities are essential to any good organization and whether they are constructive, critical, or just a nuisance, they tend to keep the majorities on their toes.—W. B. Harm, M.D., in *Detroit Medical News.*

QUININE SYNTHESIZED

The discovery of a method of synthesizing quinine by Woodward and Doering constitutes a milestone in chemotherapy.

Quinine is still the most valuable of the drugs used in the treatment of malaria, although quinacrine (U.S.P.), known under the trade name of atabrine, is of value.

The use of Peruvian bark in the treatment of malaria dates back to the seventeenth century. For many years, the supply came from South America. The attempts by England and Holland in 1850 to start chinchona plantations in India and Java proved unsuccessful because of the low quinine content of these particular trees. In 1865, however, Leger sold the Dutch government's chinchona plantation in Java one pound of seeds of a variety of trees which produced a high quinine content. In 1941, the Java trees produced 1,000 tons of quinine, almost the entire world supply. The supply is now, of course, in the hands of the Japanese.

The active alkaloid quinine was first isolated from the bark in 1820 by two French chemists, Pelletier and Carentou. Since that time, efforts to synthetize quinine have been unsuccessful until now.

As far back as 1853, quintoxin was produced from quinine by Pasteur, and in 1918, Rabe resynthesized quinine from quintoxin. In 1931, Rabe was able to synthesize dihydroquinine, which, except for two H atoms, is the same as quinine. His work is said to have offered a valuable clue which the two youngsters, Woodward and Doering, followed.

Robert Burns Woodward was born in Quincy,

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Massachusetts, in 1917. He graduated from the Quincy high school at the age of sixteen, and his head already contained as much knowledge of organic chemistry as most college graduates. He entered the Massachusetts Institute of Technology at the age of sixteen, received his B.S. degree in three years and a Ph.D. in chemistry at the age of twenty, after only four years of college.

William von Eggers Doering, his co-worker, was born in Fort Worth, Texas, also in 1917. He prepared for college at the Belmont Hill school at Belmont, a suburb of Boston, entering Harvard in 1934, and receiving a B.A. in 1938. After taking postgraduate work in chemistry at Harvard, he obtained a Ph.D. in chemistry in 1943. The same year he was employed by Polaroid on a project to synthesize quinine.

The two young scientists met at Harvard in 1942, and shared the honor of having successfully developed a method for synthesizing quinine.—*Minnesota Medicine.*

NATIONAL FOUNDATION CONTINUES FIGHT

The National Foundation for Infantile Paralysis was created to carry on a fight against infantile paralysis on all fronts. Infantile paralysis, shrouded in mystery for centuries, is being studied with an intensity such as has been brought to bear on but few other diseases. Today, the need for control is greater than ever before. This disease which unquestionably has existed for thousands of years has gained greatly in importance during the present century.

Probably the first scientific description of infantile paralysis was given by Michael Underwood, a British physician, in a treatise on the diseases of children published in London in 1789. He pointed out that the treatment "chiefly depended upon" at that time was the use of "volatile and stimulating applications to the legs and thighs."

The disease, (infantile paralysis) was not reported in the United States until the latter part of the 19th century. It was but little known during the next several decades. Then the great outbreak of 1916, during which there were over 27,000 cases reported, principally from the states along the eastern seaboard, clearly revealed the complete lack of facilities for control. During the past five years, an average of 6,500 cases has been reported annually in the United States. Every state reports at

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least a minor outbreak each year, and every summer and fall serious epidemics occur in one or more widely spread areas in the United States. Today, infantile paralysis appears to be a widespread pestilence, and is reported in epidemic proportions in almost all parts of the world.—*The National Foundation for Infantile Paralysis.*

CHRONIC IRRITATION AND CANCER

We are now beginning to understand the causes of cancer. Cancer is simply an abnormal growth of the cellular tissue of the body. We do not know all of the causes that bring it into existence, but we can say without any question whatever that cancer is not infectious. We can say that while chronic irritation of susceptible tissues is not the only cause of cancer, certainly many cases of cancer are due to chronic irritation of particularly susceptible tissues. The tissues that are more susceptible than others are those that lie in places in the body where one tissue is adjacent to the line of transition with another tissue, as for example, the lip margin where skin is immediately in contact with the mucuous membrance.—*J. of the Indiana St. Med. Assn.*

CANCER AND FAMILY INCIDENCE

Studies made of the skin cancer victims suggest that breast, colon, uterus and prostate cancer show a high family incidence.—*Bull. Am. Soc. Control of Cancer.*

MEREDITH NICHOLSON SPEAKS OUT

I confess to a fear of federalized medicine. If the government added this to its numerous bureaus, the loss in the professional standards would be incalculable. The American doctor has no superior and few equals anywhere in the world. The idea of socialized medicine impresses me only by its mischievousness. One of its worst features, apart from the blow to the individual's right to choose his own medical attendant, is the lessening of the doctor's incentive to carry on his studies beyond the point where he may be licensed to practice.

I am sure many citizens share my feeling that doctoring is a very personal affair. We don't want the government assigning our doctors to us. We want the most skilled we can get and not such as some bureau official thinks is best for us.

I consider the proposed Wagner-Murray-Dingell legislation for socialized medicine one of the

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worst measures proposed in recent congresses.—*Meredith Nicholson in Indianapolis Star.*

FEAR

The instinct of self-preservation implies positive action in maintenance of life, but the dangers that threaten life must constantly be warded off. The emotional aspect of the effort to live is fear, unceasing fear. Latent though the fear may be, it is constantly present to guard against personal disintegration. Were the fear not kept in a state of repression, life would be made intolerable for man by its continuing presence. But repressing fear calls for the constant utilization of energy in order that the stored-away fear may be kept in confinement and not be permitted to escape. Such unceasing watchfulness is trying on the individual; tension develops, which must be occasionally relieved. The relief may be afforded by a game of golf, by a week-end of fishing, or by a set-to at the card table. More often than we realize, alcohol is resorted to for surcease. But in this way and in that, a balance may be maintained and personal morale preserved. It is said to be better even to blow-up occasionally than to burst.—James K. Hall, M.D., in *So. Med. and Surg.*

1800 PRESCRIPTIONS PER DOCTOR

Some 90,000 physicians in private practice wrote on an average of 1,818 prescriptions apiece, not counting refills, in 1943, according to a prescription census conducted by *Drug Topics,* a trade paper. This was an all time high in the number of prescriptions filled, and, as might be expected, the money spent for prescriptions reached a new high in 1943 too, with a per capita expense of $2.08 as against $1.69 the previous year. These figures don't meant that the nation was sicker than it's ever been before, it should be pointed out. Forty million of the prescriptions filled were for vitamins. —*Hygeia.*

ORCHIDS TO THE OLD FAMILY DOC

While Distinguished Service Crosses and Congressional Medals are being awarded to our men in the armed forces, we would like to nominate some men in civilian life for decoration. We would name the old doctors who have come out of semi-retirement to carry on a full-time practice during

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the emergency. These men are too modest to claim any credit for their action, but the rest of us know what it means for them to take their old place in the ranks.

They have reached the place where fatigue comes early in the day and stays long into the night. Long hours, long drives, exposure and loss of sleep are as dangerous to them as bullets are to our boys in the war. To know that the work one is doing may cause death at any time, and to keep on doing that work because of a sense of duty is heroism of a high order. Our hat is off to these old heroes! —J. T. Oliphant in *J. Ind. St. Med. Assn.*

TIME AND TROUBLE TAKE THEIR TOLL

Many a good doctor has earned a long rest on the Riveria di Ponente, below the Maritime Alps, but remains in the harness at home in order that his young colleagues may go to the Mediterranean, and to other parts of the world to fight it out with the enemies of our way of life. For such there must be a celestial coast with palms and pomegranates and the fragance of hyacinths.—*J. Okla. St. Med. Assn.*

LIFE IN CARAMELS

Five conscientious objector "guinea pigs" living on a life raft in the waters off Cape Cod have tested a new daily ration consisting of 10 butterscotch caramels and a pint of water which may mean the saving of lives of hundreds of shipwrecked men.

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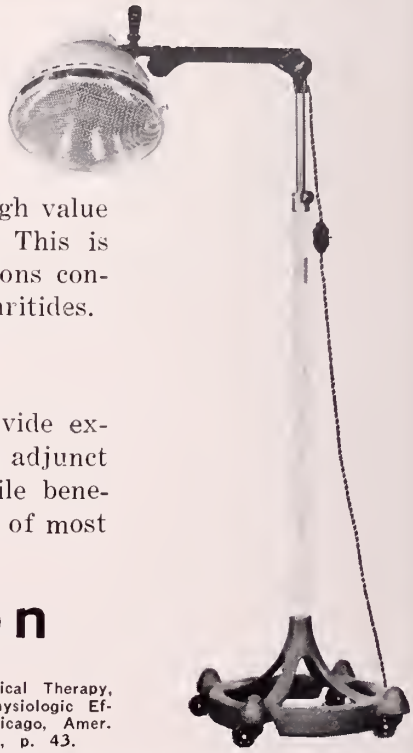

Medical literature reveals general agreement as to the high value of external heat when applied in arthritic conditions. This is in sharp contrast to the conspicuous divergence of opinions concerning any other method of management of the arthritides.

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*Handbook of Physical Therapy, Pemberton, R.: Physiologic Effects of Heat, Chicago, Amer. Med. Assoc., 1939, p. 43.

conducted the experiments under the Office of Scientific Research and Development.—*P.M.*

THE INDUSTRIAL NURSE, 1944

Old fogy that I am, I can remember when an industrial nurse's chief stock in trade was a big bottle of aspirin, a supply of roller bandages, and time on her hands. 'Tain't so, nowadays! Especially if you work in a defense plant. In the first place, you can't get in unless you have a past as pure as Whistler's Mother, and you can't stay in unless you know your stuff and have indestructible arches, and you can't get out until a business associate of J. Edgar Hoover gives you a final O.K.—Roxann in *R.N.*

N. F. VIII TO BE ISSUED IN 1945

Deletion of nearly a third of the drugs in the National Formulary and acceptance of about 115 new monographs were among the extensive changes approved by the Committee on National Formulary at its three-day session held recently at the American Institute of Pharmacy, Washington, D. C. Developmental work on N. F. VIII is now under way, and the new edition is expected to be on the pharmacist's reference shelf by the end of 1945.

The use of English instead of Latin for primary drug titles was one of the basic changes of policy authorized. This action, which overthrows a long-standing tradition in pharmaceutical compendia, was taken as a step toward a greater rationality in drug nomenclature, and in the opinion of the committee, is in conformity with the trend of modern medical science and prescribing. Latin will be retained as the secondary title, appearing in smaller type and occupying the place of present English titles. The composition and nature of N. F. drugs will be indicated in the titles to the greatest extent possible. Drugs dispensed under N. F. synonyms must also meet the official standards.

THE VICE OF THE VIRTUOUS

The peculiarity of ill-temper is that it is the vice of the virtuous. It is often the one blot on an otherwise noble character. You know men who are all but perfect, and women who would be entirely perfect but for an easily ruffled, quick-tempered, or "touchy" disposition. This compatibility of ill-temper with high moral character is one of the strangest and saddest problems of ethics.—*Henry Drummond.*

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SOME OF THE USES OF THE CUTIS (DERMA) GRAFT TRANSPLANT IN GENERAL SURGERY, ORTHOPEDIC SURGERY AND GYNECOLOGY*

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By the term "cutis graft" is meant skin from which a thin layer of epidermis has been removed with a skin graft razor. Loewe, of Frankfort-on-Main and later Rehn of the University Clinic of Freiburg, Germany, began the use of cutis in various types of plastic surgery. Loewe reported the first cases in which cutis material was used as a buried graft. He first used a strip of cutis to replace a portion of the extensor pollicis longus tendon that had been destroyed. He was able to bridge the defect. He later used cutis material in the repair of several cases of hernia and obtained satisfactory results. During and after the first World war cutis was used quite extensively in Vienna, particularly in plastic work. Several of the leading plastic surgeons in the United States at times have made use of cutis graft material for the purpose of filling in defects of contour about the head and face.

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Rodney Maingot, in his Post-Graduate Surgery, 1937, makes the following interesting comment: "While fascial suture will solve most of the problems that can possibly confront the surgeon in the way of repair, it must be remembered that fascia lata, or any aponeurosis transmitting the pull of a muscle, is strong only in the direction of that pull. Its longitudinal fibers are held together by a very few transverse ones, and large patches, even when securely anchored all around, are quite unfitted to take a strain applied equally to all their margins. The body, however, possesses in the derma a connective tissue sheet of almost unlimited size and strength, a felt-work of tough interlacing fibers equally strong in all directions."

Swenson and Harkins of Henry Ford Hospital recently reported a successful case

This method has been previously reported by the author before the Southern Surgical Association, Pinehurst, N. C., December 9, 1941; The American Association for the Surgery of Trauma, Boston, June 6, 1942; The Kanawha Medical Society, Charleston, West Virginia, February 8, 1944; and, The Central West Virginia Medical Society, Gassaway, West Virginia, April 25, 1944.

in which a cutis graft was used in the repair of an abdominal incisional hernia. Berson has lately reported favorably on the use of derma-fat-fascia transplants in the filling out of defects of body contour. However, the use of cutis graft material has not been taken up generally by the surgical profession in this country. Some have suggested that its use might lead to the formation of epidermoid cysts. This idea apparently is based on a misconception and is not correct, as to date there has been no report of a case of epidermoid cyst following the use of a cutis graft.

As regards the ultimate fate of cutis graft tissue, it has been definitely shown by Peer and Paddock that it is gradually infiltrated with and is replaced by connective tissue so that finally the graft takes on the characteristics of the structure that it replaces. For instance, in a hernial repair it is converted into fibrous tissue that resembles aponeurotic tissue and when used to replace tendon it is rapidly converted into tissue resembling tendon. When used in the reconstruction of joints like the hip and knee joints it takes on the characteristics of normal joint lining. To be more specific, cutis graft tissue can be used anywhere that fascia lata or other aponeurotic tissue has been used in the past.

MICROSCOPIC STUDIES

Rehn had microscopic studies made of skin grafts during the period of healing and noted the absorption and disappearance of the normal structures of the skin and their replacement by fibrous tissue. He likewise noted microscopic infiltration of blood vessels into the fatty undersurface of the graft in a specimen taken about the tenth day after implantation of the graft. He further noted that after five weeks had elapsed following the placement of the graft healing was apparently complete.

The most desirable location from which to remove a cutis graft is the antero-external surface of the upper third of the thigh, the skin being unusually thick in this area and also sufficiently mobile to make an easy closure of the wound caused by the excision of the graft. This type of graft material has several advantages: It is highly viable, therefore takes readily; has great tensile strength; is resistant to infection, and is easily obtainable.

INDICATIONS

Among the indications for the use of the cutis graft may be mentioned any type of hernia in which the adjacent structures are insufficient to make a completely satisfactory repair; reconstruction of joints such as the knee, hip and elbow; the correction of wobbling knees; the formation of false joints when indicated, for instance, in ankylosis of the lower jaw; for the relief and also prevention of synostosic between long bones such as in the forearm or leg; the reconstruction or reinforcement of joint ligaments; the suspension of the prolapsed cervix uteri; as suspensory material for use with the Goebel-Stoeckel operation for the relief of forms of urinary incontinence not likely to be relieved by the standard types of operation (Kelly or Kennedy technics) customarily used for that purpose; to replace areas of dura that cannot be repaired by the usual suture methods; for stage blood vessel ligations; the securing in position of bone grafts; and the filling out of defects of contour, especially of the head and face.

The accurate removal of a thin epithelial layer from the graft is important. This is best done with a skin graft razor and requires a little practice. Uihlein, also Rehn, in describing the technic, noted that the epidermis was shaved off the surface of the desired area with a skin graft knife, that afterwards the graft was cut with about 1 cm. of fat which had been left attached to its undersurface, that the gap made in the skin by the removal of the graft was usually closed with sutures and that if it was too large for this that the epidermal flap that had been removed with the skin graft knife was placed over the raw surface. The technic of cutis grafting is described also by Fomon in his "Surgery of Injury and Plastic Repair", in

accordance with the usual split skin graft technic, likewise by Ivy in his war volume concerning maxillofacial repair.

In the treatment of large incisional hernias the graft is usually cut large enough to overlap the surrounding edges for at least one-fourth inch. Two grafts may be used, one superimposed above the other in case the defect is very large, and if particularly strong reinforcement is desired. Cutis grafts are secured in position in firm tension with interrupted sutures of cotton thread, usually size No. 40, spaced about one-fourth inch apart. Moderate amounts of sulfanilamide and sulfathiazole are sprinkled into the wound and smoothly spread over all raw surfaces. No through and through tension sutures are used and no drains are placed. The obliteration of dead space in the operative wound closure is most important. The subcutaneous fat is closed with interrupted sutures of fine cotton thread. In placing these sutures usually a needle bite is taken about the center of the graft so as to bring the fat snugly in place. The grafted cutis tissue is extremely resistant to stress and strain and when properly sutured in place helps materially to make the abdominal wall or other structure secure.

ILLUSTRATIVE CASE REPORTS

Case 1.—T. L. K., white male, age 69, was admitted to the hospital April 19, 1941, for repair of a large lower right incisional hernia. He weighed 170 pounds; his blood pressure was 170 systolic, 110 diastolic. The size of the hernial bulge was approximately that of an average baby's head.

Operation May 8, 1941. The hernial sac was found to contain much omentum, also several loops of small bowel. The opening in the aponeurosis was approximately 4 by 2 inches. This was closed by use of a cutis graft taken from the patient's thigh. Up to the time of his death from coronary sclerosis in May, 1942, no sign of a recurrence had been noted.

Case 2.—B. P., white male, age 51, was admitted to the hospital May 27, 1940, with a very large epigastric hernia. The bulge on deep expiration was fully 4½ inches across. He had a small ulcerated area over the hernia, apparently due to friction from his clothing. A wire screen was placed over this and the patient was kept in the hospital for three weeks at the end of which time partial healing had taken place.

On July 9, 1940, the hernial sac was excised; the parietal peritoneum was closed by overlapping. The edges of the muscular aponeurosis could not be approximated. A cutis graft from the thigh was sutured over the defect. The patient had an uneventful convalescence. A recent check shows no evidence of recurrence. He returned to his

LEFT—
Fig. 1. Large incisional hernia previous to operation. From Ann. Surg. Vol. 115, No. 5, May, 1942.)
RIGHT—

Fig. 2. Hernia ten weeks after operation. (From Ann. Surg., Vol. 115, No. 5, May, 1942.)

former occupation of coal loading and has been getting along very well.

Case 3.—M. D., white male, age 43, was admitted to the hospital September 22, 1942, with a history of an injury to the right knee received in a mine accident, which resulted in abnormal mobility of the knee, apparently associated with defective right lateral ligaments.

This patient was operated upon September 25, 1942, by Dr. R. L. Anderson and myself. A longitudinal incision was made on the outer side of the knee, so as to expose the head of the fibula, also the external femoral condyle. A strip of cutis of suitable length and width was applied over both of these structures and secured in place with interrupted sutures. Healing was satisfactory. I have recently been advised by Dr. Anderson that the result in this case has been good.

Case 4.—Mrs. V. H., white female, age 53, was admitted to the hospital January 25, 1943. She had undergone repair of a cystocele (grade 2), and rectocele (grade 4), in August, 1941. At that time there was also noted a first degree descensus of uterus. At the time of her last admission it was noted that there had been a slight increase in the descensus of the uterus, also a slight recurrence of the cystocele.

On January 26, 1943, a subtotal hysterectomy was done. The remaining lower portion of the uterus, together with the cervix, was firmly suspended to the periosteum of the tuberculum pubis with a strip of cutis. She made an uneventful recovery. A recent check-up shows her pelvic condition to be good. The cervix is so high as to be almost beyond the reach of the examining fingers in the vagina. There is no evidence of cystocele.

Case 5.—J. H., a 7-year old colored female, was admitted to the hospital on June 22, 1943, with apparently total ankylosis of the jaw. She was unable to chew her food and was forced to subsist mainly on liquids.

Operation was performed on July 7, 1943. The ramus of the right lower jaw was divided about midway between the angle and the temporomaxillary articulation. A folded strip of cutis was implanted between the divided ends of bone. Following this procedure the child almost immediately enjoyed full use of her jaws to the extent that she was able to open her mouth and protrude her tongue without any difficulty whatever. A letter from the child's mother on February 1, 1944, was to the effect that the patient had good use of her jaws and has had no trouble in chewing her food or in opening her mouth since her discharge from the hospital.

Fig. 3. Large inguinal hernia. (From The Amer. J. Surg., vol. LIX, No. 2, February, 1943.)

Case 6.—E. J., white male, age 29, was admitted to the hospital September 29, 1943, with a comminuted fracture of the right patella.

At operation on October 11, 1943, a cutis graft strip from the right thigh was passed through a circular tunnel made in the various apon-

eurotic structures surrounding the patella. On tightening this strip of cutis tissue it was noted that the fragments of the patella were rather well approximated. The free ends of the cutis strip were firmly sewed together with interrupted cotton thread sutures. A plaster cast was applied and kept

Fig. 4. Large lower abdominal incisional hernia previous to operation. (From The Amer. J. Surg., vol. LIX, No. 2, February, 1943.)

in position for about six weeks. On October 19, a window was cut in the cast over the patellar region. The wound was well healed. The skin sutures were removed. The cast was removed on November 26, 1943. There was considerable motion in the knee. Patient has since been checked on and the knee motion has been found to be rapidly approaching normal.

My surgical associates and I in the Charleston General Hospital have made use of cutis grafts in a total of seventy-two cases, as follows: five epigastric hernias; fifteen abdominal incisional hernias (in one of these cases the patient did not take the anesthetic well and died shortly after completion of the operation, apparently from respiratory failure); one umbilical hernia; twenty-one direct and indirect inguinal hernias; one case of ankylosis of the jaw; one case of diastasis of the buccinator muscle; one case of diastasis of the recti muscles; in nine cases to suspend the uterine cervix for the relief of prolapse; in one case to suspend the uretha for the relief of urinary incontinence; five cases of wobling knee; two cases of fracture of the patella; one case of fracture of the ulna; in one case for stage ligation of the common carotid artery; one case for partial occlusion of the femoral artery; in two cases for replacement of torn dura; to support the bowel in three cases of sigmoid colostomy; one case of luxation of the acromial end of the clavicle; and one case of marked bulging of the lower abdominal aponeurosis.

In this entire list of cases there have been two small hematomas which were evacuated, three wound infections, two of them of the delayed type, and two deaths. One of the wound infections was rather persistent and some of the buried sutures had to be removed later. Another was of a mild type and involved only a small area at the lower angle of the operative incision. After evacuation it cleared up quite rapidly. In the third wound

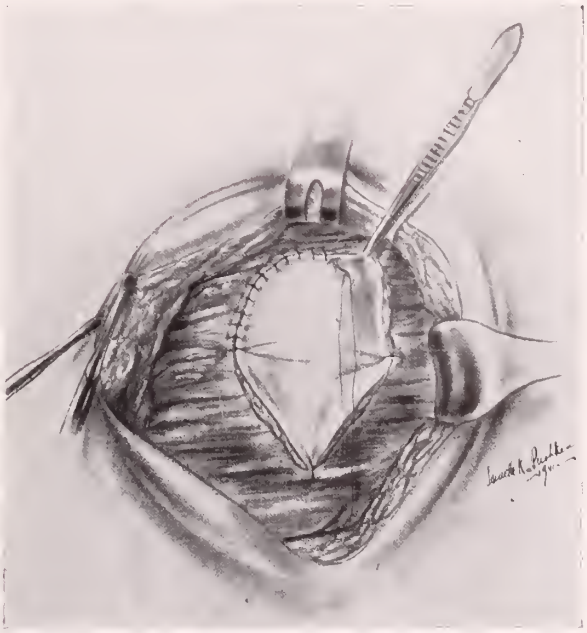

Fig. 5. Cutis graft being sutured to rectus aponeurosis. (From Ann. Surg., vol. 115, No. 5, May, 1942.)

infection, which was severe, the graft was lost. In one of the cases in which death occurred, the patient (who was extremely obese, estimated weight being between 250 and 300

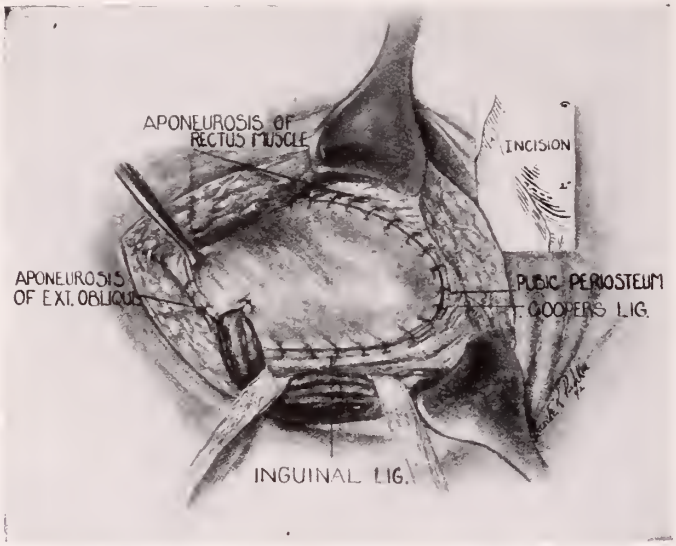

Fig. 6. Cutis graft reinforcement for inguinal hernia with defective structures. (From Ann. Surg., vol. 115, No. 5, May, 1942.)

pounds), did not take the anesthetic well and died shortly after completion of the operation, apparently from respiratory failure. The other death was that of a robust looking male 25 years of age whose heart stopped beating at the completion of a short operation in which the dislocated outer end of the clavicle had been secured in position by the use of a strip of cutis. So far as we know, there has not been any recurrence of hernia in which a cutis graft repair has been done.

SUMMARY

Cutis may be used in all cases in which the use of fascia or tendon might be indicated, with the expectation of better results. It heals rapidly and well; has great vitality; is able to survive under adverse conditions; possesses great tensile strength; has a good blood supply; gradually assumes the function of the part it replaces, and is readily available.

Its greatest value, perhaps, is in the repair of large incisional hernias. It is particularly useful in the repair of the side-slipping knee, likewise in the reconstruction of joints. It enables the surgeon to make an apparently permanent support of the uterine cervix in cases of prolapse of the uterus.

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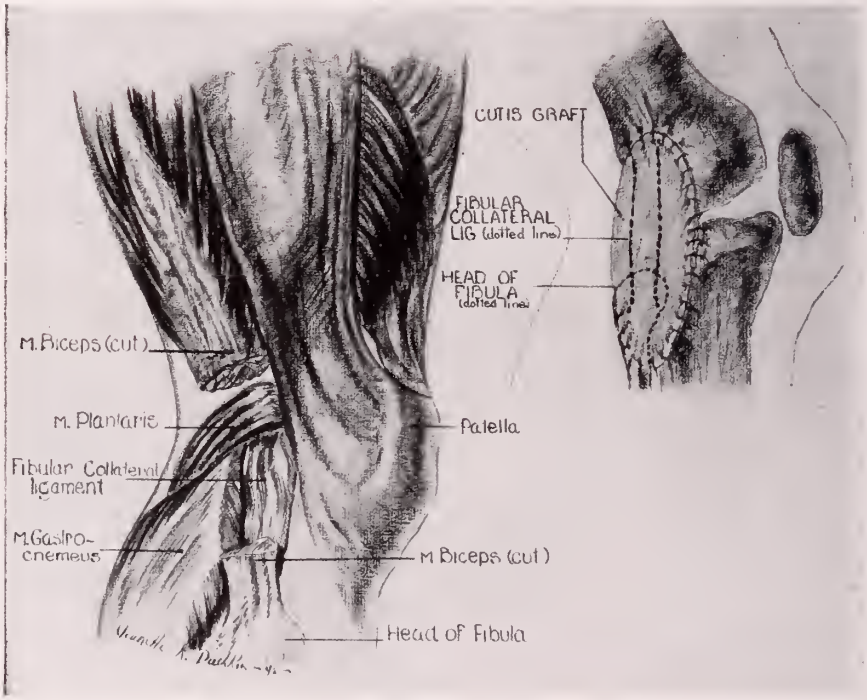

Fig. 7. Anatomy and cutis graft repair for unstable knee due to defective external lateral ligaments. (From The Amer. J. Surg., vol. LIX, No. 2, February, 1943)

THE ACCIDENTS OF PREGNANCY*

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SOMEWHAT reversing the thought of former years, there is a definite disposition nowadays to feel that the concomitant occurence of other disease conditions with pregnancy should in general be thought of and treated in the terms of those diseases. Pregnancy is recognized merely as a circumstantial incident in the course and natural history of the diseases, rather than the primary objective of treatment.

Hence in many of these cases treatment during pregnancy will not vary particularly from the treatment of the same conditions in the nonpregnant. The treatment of the pregnancy during the course of the disease conditions will be in general secondary and expectant, and will rarely call for the termination of the pregnancy.

Such diseases intercurrent with pregnancy may of course have antedated the pregnancy itself, or may be incurred during the pregnancy. Pregnancy and the intercurrent diseases have mutual reactions on each other. Pregnancy constitutes a strain on the maternal organism, increasing the strain of intercurrent diseases; intercurrent diseases are frequently prone to have a malign influence on the course or termination of pregnancy. Pregnancy is prone to aggravate, and to make more serious the prognosis of, chronic diseases and of certain acute diseases; and certain chronic diseases and many acute diseases are prone to cause unnaturally early termination of pregnancy.

But while pregnancy must be considered a strain on the maternal organism, it is almost certain that its natural course and evolution is less a strain and hazard to the mother than is its deliberate artificial termination by any means whatsoever.

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Certain acute diseases may be transmitted from the mother to the fetus, among which are smallpox and measles. Smallpox, cholera and typhoid fever are relatively infrequent in this country, and I have no personal experience with any of them.

The more common exanthematous diseases such as scarlet fever and measles do occasionally occur. Chickenpox is sometimes seen. None of these need have any specially significant bearing on the course or termination of pregnancy, nor be altered particularly in their own prognosis by reason of pregnancy. In our section of the country we seldom see in these days any except a relatively mild type of scarlet fever. A few years ago a patient under observation had two of her children sick with scarlet fever. She herself contracted the disease, was delivered at a term before the scarlet fever had fully subsided, and went through a normal puerperium without any disturbance.

It must not be forgotten moreover that puerperal septicemia sometimes is accompanied by scarlatiniform rash which may be exceedingly difficult to differentiate from true scarlet fever.

It has been believed that the early termination of pregnancy frequently associated with such infections as scarlet fever and typhoid are due to direct transmission of the

disease to the fetus. Such transmission is not seen in certain other acute diseases. A few years since a woman in extremis due to laryngeal and bronchial diphtheria was admitted in labor and gave birth spontaneously to a healthy baby. The mother succumbed to her disease, but the baby lived and thrived.

Among the most serious acute complications of pregnancy are pneumonia and influenza. In the latter condition, the maternal mortality is much higher than in the non-pregnant. In the pandemic of almost a generation ago one-half of the pregnant women suffering from influenza who developed pneumonic complications, died; more than one-half the victims of the serious type of influenza lost their babies by unnatural termination.

PREGNANCIES TERMINATED

In consideration of these two facts it was of course conceived that if these women could have their pregnancies quickly terminated, the chances of saving them might be increased. This plan of treatment, however, proved disappointing, and it soon became apparent that if they were treated expectantly, the patients did better than if artificial attempt were made to relieve them of their pregnancies. In other words, the prognosis was not improved in these cases by deliberate termination of pregnancy.

Erysipelas is a rare but serious complication of pregnancy and of the puerperium, and if occurring in the latter period, is especially prone to develop into general septicemia. Moreover there may occur in cases of true puerperal septicemia, manifestations which make differential diagnosis from erysipelas difficult or impossible.

Acute rheumatic fever may be very dangerously complicated by pregnancy. Even in the latent form of this disease, reactivation by pregnancy is by no means rare. We have several specimens of old rheumatic heart disease dating back for long periods prior to the pregnancy concerned, and apparently entirely latent in the meantime, which developed acute exacerbation of the rheumatic manifestation in the endocardium during pregnancy, the specimens showing actual fresh vegetating lesions at autopsy.

Acute gonorrhea is not in our experience very frequently seen as a complication of pregnancy. But reactivation of old foci of pelvic gonorrhea by pregnancy and labor are by no means uncommon. Such fresh exacerbations may run a serious course. I have once or twice observed fatal peritonitis resulting therefrom. Severe generalized infection is also said to result occasionally from acute gonorrheal infection in pregnancy, but has not come under my own observation.

Among chronic diseases pulmonary tuberculosis is one of the most frequent and most serious. The general consensus is that the tuberculous patient may improve in well-being and in symptoms during pregnancy, due to the general stimulation of metabolism which we know to be induced by pregnancy. On the other hand, with the rapid catabolic changes following delivery, the malign course of the tuberculous infection is apt to be accelerated. Pregnancy is therefore generally believed to be an unfortunate concomitant of pulmonary tuberculosis.

QUESTION OF TERMINATION

The question of termination of pregnancy therefor is always important in dealing with tuberculous patients. Many phthisiologists are inclined to insist on termination of pregnancy during the first trimester in active cases. Many obstetricians just as firmly believe that in general tuberculosis does not constitute a rational and valid basis for so-called therapeutic abortion. The tenor of general comment on this much debated question is tending very definitely toward a much greater degree of conservatism than was the case only a few years ago. In this connection it must not be assumed a priori that abortion in any form is a perfectly innocuous procedure. The natural evolution of pregnancy is a physiologic process, its artificial interruption an unnatural procedure fraught, even in skillful hands, with very definite danger.

If the tuberculous case can be maintained

under a regime proper for her if she were not pregnant, and the more modern surgical components of such treatments applied, as they may be, without regard to the fact of pregnancy, there are certainly very, very few cases which will justify abortion.

There has been for a long time a very general consensus that even in advanced cases of tuberculosis, interruption of pregnancy after the end of the first trimester has no salutary influence on the course of the tuberculous infection.

ABORTION NECESSARY

If occasionally, it is deemed justified and necessary to abort a tuberculous patient, the circumstances of the individual case will determine whether the pregnancy had best be terminated by abortion through the birth tract or by abdominal hysterotomy and sterilization. I object to being converted into a habitual abortionist by the ignorance, carelessness and indifference of patients, on the accidental basis of their happening to have tuberculosis. Therefor, if it does appear to be necessary to interrupt pregnancy because of tuberculosis, I believe it preferable to insure at the same time that repeated performance of this abhorrent procedure may not be necessary.

I have for a number of years been wholly conservative in my attitude on aborting tuberculosis patients. I believe that if a particular case presents potentialities of arrest by careful hygiene and management, these potentialities will not be materially lessened by pregnancy and parturition. On the other hand, if the case is so serious in its prognosis that it cannot stand the strain of pregnancy, the elimination of the pregnancy will not very definitely prolong the life expectancy.

The question of the direct transmission of tuberculosis to the fetus is not particularly pertinent to the question of managing the mother, and will be omitted from this brief discussion except to recognize the probability that it actually but rarely does occur.

Direct transmission of other diseases to the fetus has been the subject of dispute, and is actually relatively rare, as has been already indicated in discussing the acute exanthemata.

Of course, congenital syphilis has long been recognized. Syphilis is also the direct cause of a very high proportion of premature births and of puny infants of low resistance, even where actual evidence of fetal infection does not exist. This high incidence of fetal mortality may be prevented by adequate antisyphilitic treatment of the mother during her pregnancy. Inasmuch as syphilis in the mother may be so latent as not to be otherwise recognizable, the inclusion of routine Wasserman tests in any program of proper prenatal care is absolutely and invariably imperative. Fortunately the laws of many of our states at the present time recognize this. Legal insistence upon the necessity of doing routine Wassermans on every pregnant woman is not only a spur to the careless practitioner, but a potent help to the conscientious man in overcoming in some patients the reluctance of ignorance to submit to such tests.

PERSONAL IDEA

Moreover I have a personal idea, apparently borne out by repeated experience, and shared by some other obstetricians with whom I have talked, that many women with a history of premature or stillborn feti, and not manifesting actual syphilis even to serologic tests, may go successfully through subsequent pregnancies if submitted to antisyphilitic treatment during those pregnancies. For instance, I have under my care right now a young woman who has twice lost premature babies without any obvious cause. Since the birth of her last baby she has learned that her mother and three of nine siblings in the family are actually syphilitic. Although this young woman has been repeatedly negative to all serologic tests, and presents none of the stigmata of congenital syphilis, I propose, with her consent and understanding, to submit her during her current pregnancy to a full course of antisyphilitic treatment, hoping thereby to insure a healthy baby.

Treatment of the prenatal syphilitic wo-

man should be along the same lines as though she were not pregnant. Even though her syphilis is not clinically manifest except by serologic evidence, the treatment should be just as intensive as though she were not pregnant and presented a florid fresh infection. So treated, these mothers will almost invariably give birth to healthy offspring.

Malaria complicating pregnancy is not frequently encountered in my section of the country, but of course is often seen in those sections in which malaria is endemic. It undoubtedly should be treated as in the non-pregnant, without regard to the ordinary hazard of quinine in pregnancy.

Valvular heart disease is so important and frequent a concomitant of pregnancy as to constitute the necessity for the closest cooperation between the obstetrician and the cardiologist *who knows his pregnancy cases,* in any well organized obstetric service. Time will not permit a full discussion. In general the prognosis is astonishingly good in uncomplicated mitral regurgitation. In stenotic lesions with right heart dilatation and particularly with a history, or the actual occurrence, of decompensation, the prognosis is much more grave.

HEART DISEASE

Severe cases of heart disease may frequently bring into question the advisability of termination of pregnancy, either early in their course by abortion,or later, in the attempt to save the embarrassed maternal organism the further strain of pregnancy and full time parturition. Gorenberg and McGeary in our service have carefully analyzed our experience with heart disease. Their material embraces 568 cases of rheumatic heart disease, being 95% of all heart cases, and their results have been elsewhere reported. Their management is as follows:

1. All pregnant women with heart disease are examined at frequent intervals and urged to spend several hours in bed every day.

2. All patients whose measure of functional capacity prior to the pregnancy places them in Grades III or IV are hospitalized at their first visit to the clinic regardless of how well they may seem to be at the time; and kept at absolute bed rest for the remainder of the pregnancy.

3. All patients who give a history of previous decompensation are treated as Grade III or IV cardiacs; hospitalization at absolute bed rest for the remainder of the pregnancy, without regard to their functional capacity at the time first seen.

4. The cardiac patient who is more than twenty-five years of age is observed at *weekly* intervals. At the first sign of any decrease in cardiac reserve she is hospitalized and placed at absolute bed rest for the remainder of her pregnancy.

5. Special care is taken and increased bed rest ordered in every cardiac patient during the sixth, seventh, and eighth months.

6. Surgical intervention is considered contra-indicated. Labor is allowed to occur spontaneously, and cesarean section resorted to only when obstetric indications exist.

By the application of these principles of management since 1939, our failure incidence was reduced from 22.3% prior to that period, to 2.5%. A similar reduction from 3.4% to 0.64% was achieved in our death incidence.

In this management, besides the most important insistence on prolonged bed rest, three significant principles obtain:

1. No patient was aborted early in her pregnancy because of heart disease.

2. No pregnancies were terminated before term for this indication.

3. It is not believed good practice to deliver cases by cesarean section for heart disease per se.

SUPERFICIAL VARICES

Among other lesions of the circulatory system, superficial varices are frequent complications of pregnancy. Varices of the lower extremities are especially prone to be aggravated by pregnancy. When they first appear during pregnancy, if they are of mild degree, they may be adequately treated by rest and support. If more marked, they may be

treated by the now familiar injection treatment, the same as might be applied to nonpregnant individuals. In our clinic we have treated many hundreds of cases in this fashion with only rare accidents such as sloughing and ulceration at the site of injection.

Varices in other locations than the lower extremities are common, though they rarely have any true obstetric significance. Occasionally varices of the vulva or of the vagina may be the source of troublesome hemorrhage during parturition.

NEPHRITES

True nephritis is, in our experience, a rare complication of pregnancy. When seen it is usually of the hypertensive nephrosclerotic type. Prognosis for the progeny is not particularly good in these cases, inasmuch as there is a definite tendency for prematurely early spontaneous termination of the pregnancy. The maternal life expectancy is so seriously compromised that even termination of the pregnancy does not offer much hope of lengthening that expectancy.

Fixed, or essential hypertension antedating pregnancy poses one of the most serious situations in regard to the valid employment of so-called therapeutic abortion. Even in this condition, however, the issue is by no means clear-cut. Careful followup studies of fixed hypertensives by Chesley of our clinic has shown that approximately one third of them are not prejudiced in relation to their subsequent condition by pregnancy. We have no criteria as to which individuals of such material coming under observation will fall into this "immune group". So that while it is true that pregnancy undoubtedly represents an especial hazard to this whole group of patients, and that they are especially prone to the dangers of such conditions as abruption of the placenta, and more rarely of apoplexies elsewhere, it is just as certainly true that by careful medical management with adequate bed rest, many of them may be carried successfully through pregnancy and may have healthy offspring. Frequently by reason of age and economic factors they are pathetically anxious to accept every chance of successful issue of the pregnancy in spite of intelligent recognition of the extra hazards involved. One must therefore insist on careful individualization of all the cases in this group on the basis of thorough understanding, between the physician and both parents concerned, of all the factors involved.

Specific toxemias of pregnancy are omitted from this discussion because we are dealing only with the accidentally intercurrent diseases of pregnancy.

Diabetes in relation to pregnancy should be assessed and treated much as in the nonpregnant. Its incidence is not as high in pregnancy as one would expect from its general incidence in other population groups. Its high mortality in the very young, in spite of modern treatment, partly eliminates them from the pregnancy group, while the more common diabetes of middle and late middle life does not often make its appearance in the pregnant group. Moreover it is probable that diabetes actually lessens the fertility of individuals suffering from it. Nevertheless it is being more commonly encountered than it used to be, because of the fact that the life prognosis for childhood victims is better than it used to be.

LARGE SIZE INFANTS

The chief obstetric significance of the disease lies in the fact that the infants of diabetics tend to be of large size, and the diabetic mothers exhibit less resistance to infection during the puerperium than normal individuals. When infective complications do occur, they are prone to run a more malign course than in nondiabetics. The medical management of the disease, carefully applied during pregnancy will be just as salutary in handling the pregnant diabetic as the one who is not pregnant.

It has been observed that diabetics commonly do better during pregnancy than before. This is probably due to the insulin provided to the maternal organism by the fetal pancreas. In such cases the woman's clinical manifestations must be especially

carefully watched when, with the birth of the baby, this artificial augumentation of her own pancreatic deficiency is withdrawn. The newborn baby of the diabetic mother must be carefully watched for evidence of hyperinsulinism when its overacting pancreas is suddenly required to meet only the demands of its own metabolism.

ACUTE SURGICAL INFECTION

Acute surgical infections may occur in the pregnant, as in the nonpregnant. One must be constantly on guard to recognize this possibility, and also must realize the difference of clinical picture in each which pregnancy may cause. When they do occur, the surgical indications must be promptly and courageously met at any stage at which such necessity occurs. A great point to bear in mind is that surgical intervention should be carried out *without disturbance of the pregnancy* and without any fear that the pregnancy itself, or even the occurrence of parturition early in the postoperative course, will significantly complicate that course. The idea that in undertaking a laporatomy late in pregnancy, the pregnancy must be terminated prior to or concomitantly with such surgical intervention, lest the early occurrence of parturition increase the hazard of the operative surgery, is erroneous. We have more than once operated for acute appendicitis immediately before, or even during, labor. In no single instance has the occurrence of spontaneous labor early in the postoperative course disturbed that course. On the other hand, over-officiousness in attempting to combine with necessitous surgical procedure, other procedure looking to the termination of pregnancy, imposes distinctly serious and unnecessary hazard on the patient.

Minor surgical conditions are encountered in great variety and may be operated upon with entire impunity at any stage of pregnancy. This applies to dental as well as to general surgery. A listing of a few of the conditions which have been encountered in our experience will indicate their variety:

Drainage of antrum
Resection cyst of lip
Biopsy for tumor of larynx
Excision condyloma of vulva
    Fibroma of labium
    Bartholin cyst
Drainage of Bartholin abscess and abscesses in many other locations.
Revision of congenital obstruction of vagina.
Removal of polypi of cervix.
Fulguration of inflammatory lesions of cervix.
Biopsies from sternum
    Breast
    Cervix
Resection of axillary tumor
    Lipoma of buttock
    Needle in buttock
    Infected pilonidal cyst
    Fibroma of breast
Reduction of longbone fractures.

Of major surgical conditions those involving the cranium are relatively rare. We have encountered two or three brain tumors sufficiently urgent in their symptoms to warrant exploration. From the nature of the pathology of these conditions prognosis is generally grave for mothers, but sometimes a good baby may be salvaged even though the mother succumbs very shortly. Acute mastoiditis has been successfully handled.

Thyroid disease may complicate pregnancy in so acute and serious a form as to warrant operative interference during pregnancy. We have had several such cases and the surgical procedures have been thoroughly successful at various stages of pregnancy, neither the postoperative convalescence nor the pregnancy itself being in any sense jeopardized by their concomitance.

Malignant tumors of the breasts should be dealt with according to their indications without regard to the pregnancy. There is a rather widespread belief that because of the hormonal influence affecting both pregnancy, and development and activity of the breast, pregnancies occurring in the course of such serious breast conditions should be terminated. But actually most authoritative reviews of

considerable masses of such material appear to indicate that the prognosis in relation to such disease of the breast is not improved by termination of the pregnancy. Our own experience in this group of cases is small, embracing one sarcoma and three carcinomata of the breast. Unfortunately, all of our cases have been seen late, and the result of surgery was relatively hopeless. But we have no right to deny these patients the possible advantage of surgery, unless widespread metastatic development already present makes such effort entirely futile. Thoractomy for empyema and for subphrenic abscess has been performed successfully without disturbance of the concurrent pregnancy.

SURGICAL LESIONS

Acute intra-abdominal surgical lesions are those most pertinent to our interest in relation to pregnancy. The occasional necessity for operative interference in acute gallbladder disease, acute hemorrhagic pancreatitis, and acute strangulated hernia may occur. By far the most frequent is appendicitis. This should be recognized and treated even more promptly than in the nonpregnant. Differential diagnosis is often somewhat more difficult than in the nonpregnant, especially in the last trimester. However, if one bears in mind the relative frequency of its occurrence, and makes proper allowance for the dislocation of significant signs by the enlarged uterus, the diagnosis will very infrequently be missed. Once made, prompt resort to operation is imperative. Such interference should be carried through without regard for the pregnancy. Even in advanced pregnancy it is to be reiterated and emphasized that no concomitant emptying of the uterus by surgery is to be undertaken under any circumstances.

We have seen and treated operatively 64 cases of acute appendicitis complicating pregnancy and with the few exceptions hereinafter to be noted, all the patients survived and went on to successful delivery at term with the birth of living children.

Identity Adm. Date	Diagnosis & Operation	Outcome of Pregnancy	Mortality M	Mortality B
J.B. 8404 2-13-33	Normal pregnancy Ac. purulent appendicitis 8th month Appendicectomy	Premature parturition 3rd postoperative day	L	L

Difficult delivery of appendix from retroceal bed. Postoperative course completely afebrile. Early parturition DID NOT disturb it.

Identity Adm. Date	Diagnosis & Operation	Outcome of Pregnancy	Mortality M	Mortality B
F.S. 13229 4-21-33	Nephritic toxemia pregnancy Missed abortion 4th mo. Ac. gangrenous appendicitis 7th month Appendicectomy	Spontaneous extrusion conception product 3rd postoperative day	L	D

No postoperative morbidity. Death of baby not related to appendicitis. Abortion did not disturb course.

Identity Adm. Date	Diagnosis & Operation	Outcome of Pregnancy	Mortality M	Mortality B
J.H. 19680 12-20-34	Normal pregnancy Ruptured gangrenous appendicitis with twisted pedicle cyst of ovary and peritonitis, intrapartum Appendicectomy Drainage	Normal parturition Low forceps to expedite 1st day postoperative	L	L

This case was reported in detail by Norton and Connell. Actual labor had begun before operation which did not essentially modify the course of labor. Labor did not modify smooth postoperative convalescence.

Identity Adm. Date	Diagnosis & Operation	Outcome of Pregnancy	Mortality M	Mortality B
B.E. 993 11-23-35	Abnormal pregnancy Cornual implantation Threatened abortion Ac. catarrhal Appendicitis 3rd month Appendicectomy	Spontaneous complete abortion 28 days postoperative	L	D

Death of baby dependent on abnormal implantation. Operation did not hasten outcome.

Identity Adm. Date	Diagnosis & Operation	Outcome of Pregnancy	Mortality M	Mortality B
M.N. 25259 12-29-35	Normal pregnancy Recurrent ac. ulcerative appendicitis 3rd mo. large lutein cyst left ovary Appendicectomy Oophorectomy	Aborted, spontaneously completely 6th postoperative day	L	D

Fetal death due to ovarian pathology and removal. Abortion did not disturb an afebrile course.

Identity Adm. Date	Diagnosis & Operation	Outcome of Pregnancy	Mortality M	Mortality B
M.D. 23958 8-27-35	Normal pregnancy Ac. perforated appendicitis with general peritonitis, 8th month Appendicectomy, drainage, secondary drainage Laparotomy, enterostomy	Spontaneous premature delivery 10 days postoperatively	D	L

Patient admitted 2 days after onset, with repeated purgation during that interval, and with extensive generalized peritonitis. Immediate prognosis was very grave, and course so unsatisfactory that

secondary drainage operation was performed before labor had occurred, and could be assessed as a factor of disturbance. Fatal outcome believed to depend on delayed diagnosis and early mismanagement, and to be expected even had patient not been pregnant. Probably augmentation of original operative shock by any method of emptying uterus at that time would have been fatal.

Identity Adm. Date	Diagnosis & Operation	Outcome of Pregnancy	Mortality M	Mortality B
H.K. 26461 8-20-36	Normal pregnancy Ac. purulent appendicitis Appendicectomy Drainage	Normal parturition 24 hours postoperative	L	L

Local purulent peritonitis present. Appendix was exposed with much difficulty. Only two days postoperative febrile morbidity. Labor did not modify the good postoperative course.

Identity Adm. Date	Diagnosis & Operation	Outcome of Pregnancy	Mortality M	Mortality B
H.M. 28154 10-27-36	Normal pregnancy, term, in labor, ac. purulent appendicitis Intrapartum Appendicectomy Intrapartum	Normal parturition 24 hours Postoperative	L	L

Active labor commenced at least two hours before operation, and perhaps earlier, and it was hard to distinguish labor contraction in the presence of the severe inflammatory pain, so that operation did not initiate labor nor modify its normal evolution. Neither did labor modify a smooth postoperative course marked by only two days febrile morbidity.

Identity Adm. Date	Diagnosis & Operation	Outcome of Pregnancy	Mortality M	Mortality B
H.M. 28154 10-27-36	Acute purulent appendicitis Intrapartum Appendicectomy	Delivered spontaneously 24 hours later	L	L

Smooth postoperative and postpartum course. Discharged from hospital on 15th postpartum day.

Identity Adm. Date	Diagnosis & Operation	Outcome of Pregnancy	Mortality M	Mortality B
S.C. 37247 6-5-40	Normal pregnancy 5th month ac. purulent appendicitis with general peritonitis	Spontaneous complete abortion 3rd postoperative day	L	L

Abortion early in postoperative course in very sick patient did not disturb good progress.

Identity Adm. Date	Diagnosis & Operation	Outcome of Pregnancy	Mortality M	Mortality B
A.E. 48916 6-20-42	Mild preeclampsia, 38 weeks, not in labor; ac. purulent appendicitis with peritonitis	Precipitate delivery 1½ hours after operation	L	L

Delivery immediately after operation in no way complicated postoperative course.

Identity Adm. Date	Diagnosis & Operation	Outcome of Pregnancy	Mortality M	Mortality B
A.M. 49235 10-5-43	Acute appendicitis 28th week	Premature delivery 4th postoperative day	L	D

Mother's good course postoperatively and puerperally not disturbed by closeness of two experiences.

Tumors of the uterus and its adnexa furnish the next most frequent and interesting group of conditions encountered in pregnancy. In regard to fibromyomata of the uterus itself, the general attitude should be conservative. Rarely such tumors situated low down in the uterus, and of considerable size, may block the birth passage and have to be dealt with surgically, either by hysterestomy or by removal of the tumor as part of surgical emptying of uterus. The same necessity for operative interference may rarely depend upon pedunculated tumors with twisted pedicle, or even more rarely, intramural tumors undergoing acute degeneration. Even in this last group, however, acute symptoms will generally subside under expectant treatment.

TUMORS

Tumors of the ovaries should in general be dealt with on a rather more radical basis, no matter what their nature. If their removal takes place after the placenta has taken over its share in the production of luteinizing hormones, the pregnancy will not be disturbed by their extirpation. Therefore any such tumors which by their nature or size would warrant surgical removal in the nonpregnant should be removed in spite of their complicating pregnancy. The urgency of operative interference is of course very much greater should twisting of their pedicles give rise to acute symptoms. We have had only a very moderate incidence of such conditions demanding surgical intervention.

Sometimes bizarre conditions not diagnosable except by exploration occur. One such was intrapartum spontaneous rupture of a varix on the serous surface of the corpus uteri; another, the similar rupture of a varix on the surface of a large ovarian tumor; a third, rupture of a miliary aneurysm of the splenic artery.

Surgical intervention for diseases of the urinary system are relatively very infrequent. The very common infections of the urinary tract may be appropriately treated by expec-

tant measures, including sometimes ureteral and kidney-pelvis drainage and lavage. Occasionally however true surgical infections of the whole kidney may occur in such severe form as to warrant nephrectomy, or calculus disease may necessitate nephrotomy or other measures for its relief. Such surgery should unhesitatingly be undertaken according to the surgical indication without reference to the pregnancy. We have had three.

Summary: 1. It is almost axiomatic that no matter what the accidental occurrence of medical or surgical complications during the course of pregnancy may be, the appropriate medical and surgical treatment of these conditions should be carried out without disturbance of the pregnancy.

2. Inasmuch as pregnancy and the concomitant disease may affect each other adversely, the concomitant occurrence of pregnancy during the course of some of these diseases makes the intensity, so to speak, of adequate medical treatment the more important. This is strikingly exemplified in the management of tuberculosis and of heart disease.

3. Once more it is worth reiterating: Treat medical diseases medically; treat surgical diseases surgically. Do not obtrude artificial midwifery procedures into such management, for all such artificial interference is meddlesome and harmful.

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DECLINE IN SUICIDE RATE

It is a familiar fact that suicides decline during wartime, and the experience in the present war follows the established pattern. In the two years following Pearl Harber, 1942 and 1943, the suicide rate among the many millions of Metropolitan Industrial policyholders was lower by about one-fifth than the rate for the preceding three years. Actually, the downward trend of the mortality, paralleling the experience in the last war, began about the time of the outbreak of the conflict in Europe, antedating our active participation as a belligerent.

In 1943 the suicide death rate among these insured, as in the general population of the United States, established a new low record. The standardized death rate last year among these policyholders at ages 1 to 74 years was 6.8 per 100,000, as compared with 7.7 recorded in 1942 and 8.2 per 100,000 in 1941. Moreover, so far in 1944, the indications are that the death toll from suicide is being still further reduced, a good evidence of our high wartime morale. . . .

The general decline in the suicide rate in recent years may be attributed chiefly to the prevalence of favorable economic conditions and to the psychological effect of the war. . . .

Even now suicide takes considerably more than 13,000 lives a year in the United States. Much of this social wastage can probably be prevented.—*Statistical Bulletin, Metropolitan Life Ins. Co.*

GERIATRISTS NEEDED

What is medicine doing to plan for the future? The recent increase in the birth rate means an increased demand for pediatricians in the near future. The preventive medicine in the last three decades bids fair to change the character of the population in the next two decades. Where are the geriatrists to be found? What are schools and societies doing to diffuse knowledge of diseases of older people? Medicine can remain individualistic and still participate in a planned society.—*Roving Reporter in J. Missouri State Med. Assn.*

EXTINGUISH THE SPARKS

Just as we expect the world to organize to prevent war anywhere before it gets started, so we look forward to the time when all countries will combine to extinguish the sparks of pestilence before the flames begin to spread.—*Wilbur A. Sawyer in Bulletin N. Y. Acad. Med.*

SOME DANGERS OF VENOCLYSIS IN CARDIOVASCULAR DISEASE*

By ROBERT A. HOUSTON, M. D.,
Elkins, West Virginia

INTRAVENOUS infusion has become a very popular and valuable therapeutic measure in modern medicine. The methods of preparation, and the equipment for handling and administering solutions have become so nearly perfected that it is now possible for the majority of doctors to take advantage of this means of treatment whether it is needed in the hospital, in the home, or even on the field of battle. However, as with many of our newer and more successful methods of treatment, it is quite possible that the profession in its enthusiasm may not only be using venoclysis improperly and where there is no specific indication, but may even be using it in cases where it does harm.

Cases, in this hospital and other institutions, in which the patient has very suddenly died during the administration of a nontoxic solution such as normal saline and glucose have come to the attention of members of our staff. These deaths apparently were not due to the disease being treated. In all instances the cases have been patients with cardiac disease or elderly people in whom there was a possibility of the existence of cardiac disease. We cannot state definitely that the patients which we observed died as a result of overloading a diseased cardiovascular system. Much less have we a right to assume that this factor definitely caused death in those cases which have come to our attention. However, it might be well if we considered the possible untoward effects of intravenous infusions on patients with cardiovascular disease, and on those with certain pulmonary conditions which increase the burden of the right side of the heart. In this discussion I am considering only the effect produced by the volume of the infusion, and not the specific pharmacological action of the drugs contained in the solution.

In Blumer's system of "Therapeutics of Internal Medicine" William Bruckner lists the following absolute contraindications to intravenous infusions: (1) when the desired effect may be obtained just as effectively by a simpler route and (2) when a patient is known to be sensitive to a particular substance. He states that the following conditions are to be given careful consideration: cardiac insufficiency, pulmonary edema, peripheral edema.

THE AUTHOR

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Probably many of us trespass upon the first absolute contraindication in that we use this form of treatment when it is not necessary. The public has become well acquainted with "feeding by vein" and often expects it regardless of the indications. It is not unlikely that we may succumb at times to the temptation to impress the family by using the more dramatic form of therapy. Some surgical services prescribe venoclysis routinely in all cases of major surgery regardless of specific indications or of the possible harm it may do.

The question of personal idiosyncracy is obvious and applies to all methods of administering medication and is not specifically related to the increase in blood volume. However, it is in cases where there is cardiac disease, pulmonary pathology, or peripheral edema that more careful consideration is often necessary before instituting venoclysis. Peripheral edema is a symptom of an underlying condition and calls for an effort to determine the cause. If the edema is due to the hypoproteinemia of nephrosis, the nephrotic stage of nephritis, liver disease, nutritional deficiencies, etc., it would seem logical

to attempt the elevation of serum protein by infusions of plasma even though there is no agreement as to the efficacy of this method of treatment. Edema as a result of cardiovascular or cardiovascular renal disease is due to a different mechanism and, in these cases, would constitute a strong point against infusions. The edema of the final stage of chronic glomerular nephritis and other diseases causing chronically contracted kidneys is probably due to heart failure and not to salt and water retention as was previously thought.

Following the injection of large quantities of normal saline the blood volume is increased. This increase is only temporary and according to Best and Taylor the circulating volume returns to normal in thirty minutes or less. Increase in the blood volume results in increase in the blood pressure, both systolic and diastolic, indicating an added burden to the heart and the vascular system.

E. P. Sharpey-Shafer and J. Wallace report some experiments in overloading the circulatory system with intravenous injections in twelve normal subjects (British Medical Journal, Sept. 12, 1942). The injections were made more rapidly than is usual in routine practice. The venous pressure was raised to as high as 11 cm. of water above the subject's normal. Roentgenograms showed an increase in the diastolic size of the heart, enlargement of the pulmonary arteries and prominence of the vascular markings in the pulmonary fields. Vital capacity was diminished but there was no evidence of pulmonary edema. Four of the subjects showed electrocardiographic changes of stress of the right side of the heart. There was a rapid return to normal of venous pressure with cessation of the injections. This experiment confirms what one would naturally deduce from a knowledge of the anatomy of the circulation, viz., that if a large amount of fluid is injected rapidly into the vein it will increase appreciably the volume of the returning venous blood and consequently the load on the right side of the heart to a greater extent than that on the left.

There are certain pulmonary conditions which cause strain on the right side of the heart, producing the so-called *cor pulmonale*. The main cause of acute *cor pulmonale is* infarction of the lung due to massive embolism or multiple emboli escaping into the pulmonary circulation or possibly due to local thrombosis. In this condition the patient is often in shock, and there may be the impulse to try the usual intravenous therapy for shock. However this would add work to the already overloaded right side of the heart and increase the tendency to pulmonary edema which is often an accompaniment. In fact, some authorities have advocated venesection in the treatment of massive pulmonary embolism to relieve the edema in the lung. Chronic *cor pulmonale* is due to extensive fibrotic changes in the lung as seen in chronic emphysema, silicosis, pulmonary endarteritis and repeated showers of emboli. If, during an intercurrent infection or at the time of a necessary surgical procedure, venoclysis seems necessary it should certainly be given with caution if this condition is present.

DECOMPENSATED HEART

In any patient whose heart is decompensated, either with or without peripheral edema, it is rarely, if ever, that infusions of any sizeable quantity are justified. I would hesitate even to give large amounts of fluids to anyone whose heart at the time was compensated but had at some previous time been in failure. In cases of valvular lesions, regardless of whether of not there has been failure, greater caution should be exercised in administering venoclysis, for sooner or later failure will develop barring early death by some other cause, and any sudden increase of burden in addition to that imposed by the disease which is being treated might be the last straw. Dr. Whipple of our surgical staff reports a fatality which occurred on his service during his residency, illustrating this point: An appendectomy was performed on a 25 year old woman whose past history was negative for any cardiac condition. Even

though the appendectomy was an uncomplicated procedure the routine intravenous infusion was given. Shortly after this, symptoms of mild shock appeared and another infusion was given. There were no signs of abdominal complications. The patient soon became dyspneic and cyanotic and some rales were heard at the bases. A presumptive diagnosis of pulmonary embolism was made and heparin was administered in additional intravenous fluids. Shortly before death it was discovered that the patient probably had a mitral stenosis. Autopsy confirmed this clinical impression. It also revealed the heart to be greatly dilated on the right side. There was no evidence of pulmonary embolic phenomena, nor was any other pathologic process found which would explain the death. The assumption was that the patient died of acute heart failure occurring on mitral rheumatic heart disease. Obviously fluids did more harm than good in this case.

INJECTION OF FLUIDS

If, as we have assumed, the injection of large amounts of fluids into the venous system may have a deleterious effect on the cardiovascular system, those patients who have hypertensive or coronary heart disease would probably be the ones most likely to be the casualties as a result of this form of treatment. It is these cases which are the most likely to be overlooked. The prostration of the acute illness under treatment or the bed rest may cause the blood pressure to be normal in a person with hypertensive heart disease. Often no murmur will be heard in either hypertensive or coronary heart disease and unless one takes into account the past history and by a thorough check-up evaluates the possible degenerative changes which may be taking place in the cardiovascular renal system, these chronic changes may be overlooked in favor of the more acute condition to be treated. In these conditions there is already myocardial weakness and if the disease has been present for any length of time the vascular bed has lost the elasticity which responds readily to sudden changes in blood volume. This would further add to the strain on the heart. I know of three cases in which death occurred suddenly in elderly people during or immediately following venoclysis. One case was in this hospital and the other two were in other institutions, and in none was the disease of such seriousness as to warrant the unfavorable outcome. The physician in charge in each case was greatly surprised and chagrined and in only one case was cardiac disease suspected before death. It is impossible to say with any certainty just what caused death in these cases, yet it is necessary to consider the venoclysis as a possible contributing factor. Hypertensive heart disease and coronary heart disease are not necessarily contraindications to large infusions, for this form of treatment has been used hundreds of times with no untoward reaction, but I do believe it is likely to cause death in some cases if due caution is not observed. By this I mean that beyond the usual precautions the infusion should be given very slowly and with careful observation so that it can be discontinued at the first sign of reaction. In many instances small injections at intervals or even subcutaneous injections would be preferable.

Infusions are rarely, if ever, indicated in the treatment of specific heart diseases. In a failing heart 50 per cent glucose is sometimes used in quantities of 50 cc. or 100 cc. This amount, however, would cause no appreciable increase in blood volume. In the treatment of shock of coronary thrombosis some cardiologists advise intravenous injection of saline and glucose. This is not a common practice though, and it would seem to me to be a questionable form of treatment, especially since pulmonary edema develops in so many of these cases. The mechanism of this type of shock is not the same as that due to the loss of large quantities of body fluids.

CONCLUSIONS

It is difficult to prove that any one death was brought about by a specific form of

therapy used. However if we agree to the accepted physiological principles which I have brought out in this discussion, we must admit that it is not at all unlikely that harm can result from venoclysis, especially if in certain types of cases it is not properly used. Most of these cases are those in which the increased blood volume may add to the burden of a cardiovascular system already under strain.

WAR CREDITS AND DEBITS

Few are the items that can be listed on the credit side of war. A few surgical procedures such as improvement of technique in amputation of limbs, debridement, the Carrel Dakin irrigation of wounds, the Orr treatment of osteomyelitis resulted from war experience. Most of the advances in the discovery of the cause of disease, its prevention and treatment have been made during peacetime.

As outgrowths of war may be mentioned the development of the military hospital which can be traced back to the time of the Crusades when a monk, Brother Gerard, founded the hospital of St. John in Jerusalem open to Mohammedan, Jew and Christian alike. The development of the profession of trained nurse dates back to Florence Nightingale and the Crimean War. It was a Swiss Henry Dunant who as a spectator at the bloody battle of Solferina in Italy in 1859, conceived the idea of the Red Cross, the first Congress of which met in Geneva in 1863. Clara Barton, an American woman was in Berne, Switzerland, in 1870 at the outbreak of the Franco Prussian War. She joined the German Red Cross and after the war on her return to this country succeeded after nine years of perseverance in inducing Congress to join the International Red Cross as the thirty-second nation to join.

On the debit side of war is the slaughter of the best physical specimens of manhood of the countries involved and the resultant physical and mental wrecks resulting from war wounds and disease. Disease and starvation, in civilian population, to say nothing of the destruction of property only add to the sum total of war devastation.—*Carl B. Drake, M.D., in Minnesota Medicine.*

VALUE OF VACCINATION

A recent survey in Colombia disclosed only one case of yellow fever in over 600,000 persons vaccinated against the disease.—*Detroit Medical News.*

Tuberculosis Abstracts

Furnished Through the Courtesy of
The West Virginia Tuberculosis Association

Tuberculosis in Schools

The Legislative Assembly of the Province of Quebec on May 17, 1941 unanimously passed an act stating that no person could teach in a public, private or independent school unless he produces every year a physician's certificate stating that he "suffers from no infirmity or disease which renders him unfit for teaching" and "a certificate from a phthisiologist attesting that a clinical and radiological pulmonary examination shows that such person is free from tuberculous disease." Such examination must be made within two months following the engagement. Should any teacher prove to be tuberculous the contract to teach is immediately rescinded.

If Quebec glories in being the first province in Canada to pass such a law it must be admitted that it is the one to need it most—having the highest death rate from tuberculosis among the Canadian provinces. Three factors led to the passage of the law. First, a three-year educational campaign on tuberculosis which reached most of the population; second, a law passed by the city of Quebec requiring all teachers of the School Commission to undergo examination for tuberculosis, including a chest X-ray. Out of 523 teachers examined 16 were withdrawn from teaching because of active or chronic tuberculosis. The third factor was a personal experience published in an educational review which demonstrated mass contamination of pupils by a tuberculous teacher.

The legislation was introduced by the Council of Education of which all the bishops of the Province are members, so the doors of the teaching religious congregations were thrown open.

Difficulties arose in the enforcement of this new law as was to be expected, but these were overcome as the organization proceeded. In rural districts the expense was borne by the Board of Health, in Montreal the Catholic and Protestant school commissions paid for the x-ray films.

Detection of Tuberculosis in School Teachers in the Province of Quebec, L. Laberge, M.D., Canadian Journal of Public Health, March, 1943.

The President's Page

For some the month of August was just another month. For others it meant unending hardships, toil and strife on the battlefields of the world, but for a few fortunate others, it meant fishing in an old favorite stream or lake. Some of you may remember that I once referred to that "same old lake in Canada" where "blue horizons" were seen, where "hot suns settled in the west," where "days were done," but where also were seen "the glories of the dawn." I have just witnessed all those wonderful sights again, and managed to intermingle several hours of man's greatest pasttime, the gentle art of fishing.

To you busy doctors who have never found the time nor had the inclination to indulge in this oldest of sports, let me tell you that you have missed one of life's greatest diversions. No doctor is immune to the trials and tribulations of the practice of medicine. All doctors advise some patients every day to take time off, rest a lot, play a bit, or if you like, fish or hunt a bit, but how many of those same doctors ever find time to do likewise. Consequently it is reported that the members of our profession head the list in deaths from coronary disease. You owe to yourself, your family, and your profession, the healthy continuation of your life as long as possible, and I know of no prescription to take the place of fishing, either in small or large doses, taken regularly each year.

President.

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MEDICAL EDUCATION IN DANGER

With the possible exception of the enactment of the vicious Wagner-Murray-Dingell bill, no greater calamity could befall the medical profession, the hospital and civilians generally than the refusal of Congress to heed the urgent plea that at least 6,000 premedical and medical students be deferred annually in order to complete their medical education.

In closing the doors of medical colleges to all premedical and medical students not enrolled by July 1, 1944, Selective Service has, in effect, created an annual deficit of probably 2,000 doctors. Appeals of doctors and medical educators the country over to Selective Service, the Army and Navy and even the President, have so far been of no avail. The whole system of medical education is in danger, and it seems that the only remedy left is direct action by Congress.

Congressman Louis E. Miller of Missouri, himself a doctor, has introduced a bill (H.B. 5128) in the House directing Selective Service to defer annually not less than 6,000 medical and premedical students and 4,000 dental and predental students. Enactment of this bill would undoubtedly prevent a large deficit in medical and dental school graduates.

The attention of all members of the West Virginia delegation in Congress was called to this matter late in July by the headquarters office of the State Medical Association. Both senators and all of our congressmen have promised to give careful consideration to the provisions of the Miller bill. Some, quick to recognize the dangers of the present situation, have taken a firm stand in favor of the bill. They realize that within a matter of months hospitals might be faced with the necessity of operating without interns and residents, not only a dangerous but almost an impossible situation. Medical schools will be in a state of disorganization since it will be impossible to fill the enrollment with women and 4-F students.

POLIOMYELITIS

While the number of cases of acute anterior poliomyelitis reported in our own state is about the average of nonepidemic years, several of our neighbors have the disease in epidemic proportions, notably Kentucky, Virginia, and both Carolinas. The reporting of the disease is imperative. The handling of the individual cases in New York State has been modified as far as contact with other patients is concerned. Upon the unanimous recommendation of the Advisory Group on Poliomyelitis, the Public Health Council of New York State has adopted the following resolutions:

1. That all patients in whom a diagnosis of anterior poliomyelitis is suspected should be cared for in a hospital and that these patients may be safely admitted to the general wards but that it might be desirable to separate the patients in special wards for ease in handling.

2. That quarantine procedures in hospitals be eliminated but that concurrent disinfection of all excretions be continued.

We urge upon each physician the absolute

necessity of prompt reporting of all cases and the desirability of prompt hospital treatment. We publish the New York resolutions as showing a trend, but isolation is required of acute cases in our own state.

NOT A TWICE-TOLD TALE

This is a story of Ernie Pyle and Dr. Lucien M. Strawn, of Morgantown, and of why Ernie's tale was not twice-told.

Captain Strawn, MC, AUS, was commissioned a lieutenant in July, 1942, and assigned to Camp Gordon, Georgia. He has been serving heroically in the front lines on the western front, and eventually Ernie Pyle caught up with him and wrote two interesting stories in which he figured prominently. These stories were printed in papers all over the United States the middle of August.

Ernie Pyle is one of our favorite columnists, and he is probably read more widely than any other American columnist, even including the late Raymond Clapper. He has in many ways taken the place of our friend and neighbor from Gallipolis, Ohio, the late O. O. McIntire. It was perfectly natural, then, that we should ask permission to reprint the articles with proper credit line. We felt that the item concerning Doctor Strawn would add much to the newsworthiness of our "With Doctors in the Service" section in the September issue. The pay off comes in the nature of a wire from the syndicate through which the Pyle articles are distributed, authorizing use of the stories upon the payment of a substantial sum.

We do not know who controls United Feature Syndicate. That doesn't matter. What does matter is that it is the first time that any publisher, syndicate, or author has demanded tribute from us other than a credit line for the right to reprint an article, whether scientific or news. The West Virginia Medical Journal, the official organ of the State Medical Association, a non-profit organization, is furnished gratis to all the members of the Association, not only in civilian practice but on every battlefront of the world. Inasmuch as we haven't reached the point where we think it advisable or necessary to pay folding money even for a half page of original copy, to say nothing of a reprint of an article which has already been used in newspapers throughout the country, we immediately lost our enthusiasm.

This was not Ernie Pyle's doing, and notwithstanding the bad taste left in our mouth by United Feature Syndicate's action, we are still for him one hundred per cent and shall continue to look forward each day to reading his graphic reports of the war on the western front. In the Journal, we shall confine ourselves to the publication of interesting items concerning our doctors in the service, furnished to us without charge by the doctors themselves and their friends all over the world.

A FORWARD STEP

The Washington office of the Council on Medical Service and Public Relations of the American Medical Association at 1835 Eye Street, N. W., has now been open since April. Dr. Joseph S. Lawrence, who was for many years Executive Officer of the Medical Society of the State of New York, has been named Director. Relative to the development of the Washington office, we quote from a recent issue of the *Journal of the American Medical Association*:

"The Washington office of the Council was opened on April 3, 1944, at 1835 Eye Street, N. W. Dr. Joseph S. Lawrence, Executive Officer of the Medical Society of the State of New York, was secured as a consultant and the development of the office placed under his direction. Reactions to this office have been favorable. Much needs to be done in organizing the states to cooperate with the office. Each state should designate a representative who will be the contact man with the Washington office so that information may be promptly circulated through the proper channels. Conferences with the states should be held at intervals to insure maximum efficiency in functioning. Two such conferences have already been held with the New England States and New Jersey. On June 11 another conference was held with other states here in Chi-

cago. These conferences should be held from time to time in the future. Hence, the Council recommends that the proper organization of the Washington office should consist of a full-time director, subject to the Council; that there should be a field agent whose duties it shall be to maintain personal contact with state associations and keep them informed of the activities of the Council; such clerical help as may be necessary; and, eventually, a legal adviser, who at first will be on a part-time basis. There will be close collaboration between the Washington office and the Bureau of Legal Medicine and Legislation.

"The Council realizes that it has been criticized because it has moved slowly with reference to the Washington office. We feel that it has been most important to move slowly so that anything done would not have to be undone. The matter is now on a solid basis, which will result in a constructive program and redound to the credit and benefit of the Association. One hasty action might well have set us back years.

"The bulletins issued by the Council have been well received, but they can be improved on. When the Washington office is functioning with a full-time staff, great improvement can and will be made in them."

Dr. Lawrence was consultant to the Washington office from its opening in April and is now in complete charge, and is organizing and developing the work there. He is probably the best fitted man in America for this position. His personality is especially pleasing and his long experience in New York State with medical legislative matters and the public relations aspect of medicine bespeak for him success in his work in the National Capital.

ANNUAL MEETING MAY 14-15, 1944

The 78th annual meeting of the West Virginia State Medical Association will be held at Clarksburg May 14-15, 1945. This marks the third successive year that the third week in May has been fixed by the Council as the time for holding the meeting. The action of the Council has the full approval of the Scientific Work Committee and the Harrison County Medical Society. The 21st annual meeting of the Woman's Auxiliary will be held at the same time.

In point of doctor attendance, the biggest meeting ever held by the Association was at Clarksburg in 1937. The overwhelming vote recorded in the House of Delegates last May for the motion to accept the invitation of the Harrison County Medical Society augurs well for the success of the meeting. Hotel accommodations are adequate, and there will be few transportation difficulties, as Clarksburg is within easy traveling distance by motor car, bus and train from every section of the state.

CANCER CONSCIOUS

The Cancer Committee, through its chairman, Dr. J. Ross Hunter, of Charleston, has asked each local medical society to devote one meeting this winter to the subject of cancer control. We expect the response to be unanimous, for we feel that doctors today are more cancer conscious than they have ever been at any time in the past. The more they discuss this disease that takes a toll of at least 1,500 lives annually in West Virginia, the better equipped they will be to recognize early symptoms and employ means not only to control cancer but to affect a cure.

The educational feature must not be overlooked. Our youngsters must be taught the necessity of early diagnosis. Parents and doctors must work together if we are to make any substantial headway.

Doctor Paul R. Gerhardt, director of the Division of Cancer Control in the State Health Department, plans to spend quite a good deal of time during the next few months in conference with doctors over the state. Meetings of component societies at which an effort is made to have a large attendance of members will afford an opportunity for a better understanding between doctors and administrative officials in charge of the new program.

CANCER AND WAR FATALITIES

Durring 1942, deaths from cancer in the U. S. totaled 163,400 according to the census bureau. Up to the end of 1943, our fatalities on all fronts in all the armed forces totaled only 29,104.

General News

MAY 14-15, 1945, FIXED BY COUNCIL AS DATES FOR 78TH ANNUAL MEETING

The Council of the West Virginia State Medical Association has fixed May 14-15, 1945, as the dates for the 78th annual meeting, which will be held at Clarksburg. The scientific sessions will be held at the Waldo Hotel, where convention headquarters will be established.

No decision has been reached concerning scientific exhibits, as the committee in charge of the exhibits has not yet been named. The Waldo, Stonewall Jackson and Gore have all been designated as convention hotels.

The first meeting of the Scientific Work Committee was held July 15 at White Sulphur Springs, at which it was decided to arrange another streamlined program. The extent of the program aside from scientific assemblies will depend largely upon the war outlook next spring. A second meeting of the program committee will be held the first of September at Clarksburg. The chairman, Dr. James L. Wade, of Parkersburg, has already indicated that several prominent, nationally known physicians will be on the program.

It is believed that a sufficient number of hotel rooms have been set aside to provide accommodations for everybody. The three hotels have pledged full cooperation and doctors are urged to file reservations for rooms without delay. Requests for reservations should be made directly to the hotels.

Nearly 500 doctors were registered at the last meeting of the State Medical Association held at Clarksburg in 1937. This registration was largely the result of the efforts of the local committee on arrangements, and it is pointed out now that doctors in nearby cities can attend the sessions and yet be able to spend a few hours each day or evening in their offices.

The large ballroom on the second mezzanine at the Waldo will be used for the scientific meetings and the two sessions of the House of Delegates. Technical exhibits will be set up on the first mezzanine. Section and special society luncheons will be held at both the Waldo and the Stonewall Jackson hotels.

IMMEDIATE TRANSFER TO HOSPITALS NOW POSSIBLE FOR POLIO PATIENTS

In order that polio victims may be given early treatment in hospitals equipped for the purpose, Dr. J. E. Offner, state health commissioner, has modified the regulation requiring three weeks' quarantine so as to permit the immediate transfer of patients from their homes to a hospital. The order is effective immediately and will continue in force until November 1. However, written permission must be obtained from the local health officer or state health department before a patient may be moved from one county to another.

Statistics to August 20

In West Virginia, 52 cases of infantile paralysis have been reported to the state health department during 1944. This total represents cases reported through August 19, and compares with 30 cases for the entire year 1943. During the epidemic in 1940, 662 cases were reported in this state, with 52 deaths.

For the period ending August 5, 1944, the National Foundation reports 205 cases in Virginia, 284 in Pennsylvania, 470 in North Carolina, 377 in Kentucky and 902 in New York.

As pointed out by Basil O'Connor, president of the National Foundation, the serious outbreaks this summer were confined almost entirely to states east of the Mississippi, while last year's were largely west of the river.

The U. S. Public Health Service reports a total of 3,992 cases to August 6, 1944. This is 1,226 more than were reported for the same period last year, and 1,089 more than in 1931. The worst outbreak occurred in 1916 when 6,767 cases were reported for the entire country by August 1, and the National Foundation is authority for the statement that in the first 31 weeks of 1944 more cases of polio have been reported in the United States than at any comparable time during the past 28 years.

Financial Aid Available

In a bulletin sent to all county chapters, James A. Bibby, of Charleston, West Virginia chairman of the National Foundation for Infantile Paralysis, reminds officials that the health department is the agency primarily responsible for all control measures. County chapters were organized for the purpose of supplementing existing facilities so that medical treatment will be available to all. He makes it clear that no victim of poliomyelitis need go untreated because of the lack of funds.

Financial aid has already been provided this year to victims in West Virginia. Funds through which the National Foundation and its many chapters carry on their work are supplied by the March of Dimes and similar activities held each January at the celebration of the President's Birthday.

USPHS UNIT FUNCTIONS AT ELKINS

The tornado which swept through parts of West Virginia on the night of June 23 resulted in several casualties and great property damage even outside the Shinnston area, where 70 persons lost their lives. Particularly was this true of the Montlives. particularly was this true of the Montrose section in Randolph county. The fine work at that time of the USPHS, which was organized around the staff of the Golden Clinic of the Davis Memorial Hospital, at Elkins, has just recently come to light.

The unit, of which Dr. Benj. I. Golden is the senior surgeon, was called into action at the time of the disaster and functioned throughout the night and on into the next day. Over fifty calls for blood plasma were met promptly and everything possible was done to alleviate the suffering of the injured.

Less than twenty-four hours after the disaster, officials of the Red Cross visited the hospital unit to discuss costs, but it was made clear to them at that time that there would be no charge by any of the members of the staff, the nurses, or the hospital for any services rendered any of the victims of the tornado. The unit was organized at Elkins December 7, 1942, for the purpose of meeting emergencies such as developed in the central part of the state late in June.

USPHS NEEDS DOCTORS

Dr. Robert K. Buford, state chairman of the Procurement and Assignment Service for Physicians, has been informed that the United States Public Health Service needs 322 physicians immediately. About 170 of these are needed for assignment to duty in the War Shipping Administration, for foreign shore duty with UNRRA, and for sea duty in the U. S. Coast Guard while 150 are needed for duty in the Rospital Division, Foreign Quarantine, Tuberculosis Control, Venereal Disease Control, and other States Relations work.

ALL DOCTORS IN MILITARY SERVICE TO BE GIVEN OPPORTUNITY TO VOTE

Early in August a letter was sent out by the State Medical Association to the latest known address of all members in the military service with reference to the method provided by the West Virginia legislature to assure all men and women of this state in the armed forces an opportunity to vote at the general election November 7, 1944. Attached was a blank request for a ballot, to be returned to the headquarters office and then relayed to the proper circuit clerks.

Requests for ballots are being received in each mail, and circuit clerks over the state have given their personal assurance that there will be no delay in sending out these ballots.

A request for a ballot to be used by a doctor away from home, whether in this country or overseas, may be filed by any person with the circuit clerk of the county in which he is a legal voter. Even if he is not registered, he will not be denied the right to vote, as William S. O'Brien, Secretary of State, has instructed all circuit clerks to consider an application for a ballot as an application for registration.

In many cases, circuit clerks are sending ballots by air mail to voters overseas. The importance of marking the ballot and returning it to the circuit clerk promptly cannot be overemphasized, as it is necessary that the ballot be in the hands of the clerk by election day for it is to be counted by election officials. All requests received by the State Medical Association are being cleared the same day and no request has yet been held up by any of the circuit or county clerks. While there is still an abundance of time left for doctors in this country, it is essential that those who are overseas file application immediately in order to allow for unavoidable delays in the delivery of mail.

EDUCATIONAL CONSULTANT NAMED

Mrs. Marian Patrick Hart, of Charleston, has been appointed by Dr. J. E. Offner, state health commissioner, as educational consultant in the division of cancer control under Dr. Paul R. Gerhardt, the director.

Mrs. Hart has been assistant chief of the division of social service in the department of public assistance for the past seven years, and has done field service in every section of West Virginia.

WEST VIRGINIA REPRESENTATIVES EXPRESS VIEWS ON MILLER BILL

The State Medical Association late in July addressed letters to the two senators and six congressmen from West Virginia with reference to the ruling of Selective Service that there will be no deferments for premedical and medical students not enrolled in medical schools by July 1, 1944. They were told that, as the result of this ruling, it is estimated that the entering class of 1945 will be reduced 25 to 30 per cent, that medical classes will be drastically curtailed, and that it will be impossible for medical schools to fill their ranks with women and 4-F students.

The main object of the letter was to bring to the attention of our delegation in Congress the bill introduced by Congressman Louis E. Miller, of Missouri, which provides for the deferment annually of not less than 6,000 medical and premedical students and 4,000 dental and predental students.

Replies received have been satisfactory in that there is no question that all of the members of the delegation understand the effect of the ruling.

U. S. Senator Chapman Revercomb, of Charleston, writes as follows:

"I heartily agree with you that the Selective Service ruling with respect to medical students and premedical students is unsound and dangerous for the future welfare of this country.

"I have discussed this situation several times here with members of Congress. It has been my hope that the ruling will be changed, but if it cannot be, legislation will have to be used to effect it.

"I will be very glad, indeed, to give consideration to the bill introduced by Representative Louis E. Miller of Missouri. In the meantime I hope to have the Selective Service ruling changed and will aid in legislation to effect the same end if a change in the regulation is not obtainable."

In a letter from U. S. Senator Harley M. Kilgore, of Beckley, he states that, "I am very glad to have the views of the members of your organization and shall bear them in mind when the measure comes to the Senate for action. It is a pleasure to hear from you and to have your comments relative to issues of public interest."

A. C. Schiffler, of Wheeling, Representative from the first district, writes that he is in full accord with the provisions of the bill, and will give it complete support when it is presented. "I wish to assure you and the members of the medical profession of my continued interest and cooperation," he says.

"You may be sure that this important subject will receive my sympathetic consideration," writes Jennings Randolph, of Elkins, Congressman from the second district. "I favor the purposes of the legislation."

"I agree with you that it is very necessary that the medical schools have an adequate number of recruits," writes E. G. Rohrbough, of Glenville, Representative from the third district "and I further believe that these recruits should not be exclusively from women and men classified as 4-F. I wish to assure you I shall do anything I can to assist in bringing about a satisfactory solution of the medical school problem."

"This bill was not introduced until June 23, 1944," writes Congressman Hubert L. Ellis, of Huntington, "and there has been no action by the House Military Affairs Committee. I am advised that the recommendations requested of the War and Navy Departments have not been received by the committee. The bill has not come to the attention of the members of the House generally for consideration. Inasmuch as the committee has held no hearings and made no report, I have not had an opportunity to give the measure careful study. However, I appreciate receiving your views, and when the bill comes before the House for action, you may be sure that I shall bear them in mind."

John Kee, of Bluefield, Representative from the sixth district, writes as follows: "In view of the present situation, this proposed measure would seem to merit prompt consideration. I will be very glad to look into the provisions of the bill at once trusting I may find it to be one to which I can conscientiously give my full support."

Congressman Joe L. Smith of Beckley, believes that the legislation to defer medical students is actually needed. "I promise you that I shall vote for the passage of this bill," he says, "if and when it is considered in Congress."

SOUTHERN DISTRICT HEALTH CONFERENCE

The annual Southern District Health Conference, covering 24 counties in West Virginia, will be held September 29 at the Daniel Boone Hotel, Charleston, at 9 A. M. Miss Leada Neininger, supervisor of nurses for the Kanawha County Health Department, is chairman of the program committee. The theme of the meeting, which will last one day, will be control of tuberculosis in West Virginia.

Section meetings of health officers, nurses and sanitarians are scheduled for the afternoon.

PARTY PLATFORM PLANKS

Social security and health programs were mentioned as follows in the Republican and Democratic platforms adopted at the national conventions held in Chicago in July.

Republican Platform

"We pledge our support of the following:

"Extension of the existing old age insurance and unemployment insurance system to all employes not already covered.

"The return of the public employment office system to the states at the earliest possible time, financed as before Pearl Harbor.

"A careful study of federal-state programs for maternal and child health, dependent children, and assistance to the blind, with a view to strengthening these programs.

"The continuation of these and other programs relating to health, and the stimulation by federal aid of state plans to make medical and hospital service available to those in need without disturbing doctor-patient relationships or socializing medicine.

"The stimulation of state and local plans to provide decent low cost housing properly financed by the federal housing administration, or otherwise, when such housing cannot be supplied or financed by private sources."

Democratic Platform

"We offer these postwar programs:

"A continuation of our policy of full benefits for ex-servicemen and women with special consideration for the disabled . . .

"The enactment of such additional humanitarian, labor, social and farm legislation as time and experience may require including the amendment or repeal of any law enacted in recent years which has failed to accomplish its purpose.

"We reassert our faith in competitive private enterprise free from control by monopolies, cartels, or any artibrary private or public authority."

NEW TERM AT WVU MEDICAL SCHOOL

The 1943-44 accelerated term of the Medical School at West Virginia University will end September 16, and then new term will begin September 25, 1944.

FORMER FAYETTEVILLE DOCTOR HONORED

Dr. Guy W. Daugherty, of Rochester, Minnesota, who was formerly located at Fayetteville, has been made a diplomate of the American Board of Internal Medicine.

RELOCATIONS

Dr. H. B. Luttrell, of Bramwell, has moved to Delaplane, Virginia.

Dr. Theodore Gallup, who has been located at Sharples for several years, has moved to Hanford, Washington.

Dr. Arthur J. Viehman, who has been a member of the staff at Hopemont Sanitarium since 1942, has accepted a place on the staff at the Tuberculosis Hospital, Price Hill, Cincinnati.

Dr. J. L. Bosworth, of Mill Creek, has relocated for the practice of his profession at Elkins.

Dr. J. K. Cooper, of Premier, is now located at Morristown, Tennessee.

Dr. F. E. LaPrade, member of the staff of Welch Emergency Hospital for several years, has moved to Tampa, Florida.

Dr. W. E. Matthews, who has been on the staff at Mercy Hospital, Logan, for several years, is now connected with Duke Hospital at Durham, North Carolina.

PHC MEETS OCT. 2-4

The regular fall meeting of the Public Health Council will be held at the Daniel Boone Hotel, Charleston, October 2-4. There are approximately twenty applicants for licensure by examination and reciprocity.

BATTLE CREEK HEALTH OFFICER

Dr. Hugh Robins, former city health commissioner at Charleston, who has served as county health officer of Calhoun County, Michigan, for the past seven years, has been appointed health officer at Battle Creek, following the merging of the city and county health units in that county. The unit will be used by the W. K. Kellogg Foundation as a center for its training and fellowship program.

Doctor Robins' brother, Dr. J. E. Robins, Jr., is now serving as city health officer at Charleston.

E. S. TISDALE GIVEN PROMOTION

E. S. Tisdale, formerly of South Charleston, has been appointed head of the Procurement and Assignment Service sanitary engineering program, with headquarters in Washington, and will direct the recruiting program which has recently been reactivated because of the need for additional sanitary engineers in the Army and the United States Public Health Service.

WITH DOCTORS IN THE SERVICE

Captain Robert M. Ferrell, of Webster Springs, is with the armed forces somewhere in Italy.

* * * *

Lt. Col. Pat A. Tuckwiller, of Charleston, was recently transferred from North Ireland to a Station Hospital in England. He writes as follows: "Captain Jacob Huffman (of Harmon) and I surely enjoy The West Virginia Medical Journal. We have a fine group of medical officers in our unit and I am very much interested in our work on this side.

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Captain Stanley Weinstein, of Huntington, is serving as chief of the anesthesia section of the Station Hospital at Camp Breckinridge, Kentucky.

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Captain Emory H. Main, of Philippi, who is now serving as flight surgeon for a bomber squadron in the Southwest Pacific, writes most interestingly concerning an experience he had while serving at a base in New Guinea.

"That morning," he says, "I went down to the flying line to fly a few trips as passenger, and found one of the co-pilots suffering from a rib injury. He had made one trip before I saw him, and, as it was obvious that he could not continue to fly, I ordered him to return to the camp area and rest.

"In the meantime, the bridge on our road was out and it was impossible to get another pilot in time. When the operations officer asked if I would take his place, I jumped at the chance. I then flew from about nine-thirty until five o'clock. Of course, take off and landing is strictly a matter for the pilot, but assistance during these operations and actually flying the plane for about one-half the time is the duty of the co-pilot. I actually logged five hours of flying as co-pilot on one of our ships in combat zone!

"When I say flying in combat zone, I mean it. Of course I cannot tell where we took off or landed, but we got down close to the ground several times and kept a sharp lookout for enemy craft. At one field where we landed we could see the flak and hear the boom of cannon."

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Dr. Carl Truman Thompson, of Morgantown, president of the Monongalia County Medical Society, has been commissioned Lieutenant Commander, MS-V(S), USNR, and ordered to active duty at the Navy Yard, Washington, D. C.

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Captain Stephen Mamick, of White Sulphur Springs, who enlisted in the army medical corps in September, 1942, is now somewhere in England. He was given his basic training at Camp Grant,

Captain Stephen Mamick, MC

Illinois, and then assigned to Walter Reed Hospital, at Washington, for a course in "Tropical Diseases." Afterwards, he was assigned to Camp Campbell, Kentucky, Fort George G. Meade, Maryland and Camp Edwards, Massachusetts. He writes that his unit in England has an abundance of medical equipment and supplies, and that casualties are being given the very best of medical care.

* * * *

Captain H. L. Hegner, of Wellsburg, who is attached to a station hospital in Italy, thinks that his unit has established a record for the number of different nationalities represented among patients who have been given treatment. His letter follows:

August 3, 1944.

Dear Mr. Lively:

Have joined the vast legion of citizens abroad. I sailed May 1 as a casual replacement and landed at Oran in North Africa. There some good fortune favored me in that I was given an excellent assignment. Am with a station hospital which beat me out of Africa and I had to join it here in Italy.

The set up is excellent. A good group to work with, and I am in surgical service with plenty to do and little interference from anyone. We are quartered in buildings in what was in peace time an Italian military barracks. The buildings, set in quadrangle fashion, are in turn surrounded by a high wall.

I think we have set the record for varied nationalities of patients. We treat all the allies.—American, French, British, and Italian, army, navy and merchant marine;

Greeks. Africans. New Zealanders. Australians. Indians. Gouns. Moroccan and Algerian Arabs: and now Brazilians. Makes one grand pot pourri.

Rather isolated on a coastal highway, we are the only hospital in over a hundred miles, which fact keeps us rather busy. The actual combat wasn't very far removed from here when we arrived. All the news continues good, and the end over here isn't in the too distant future, for which we are all very happy. Received one copy of The Journal in Africa, but hope to receive them more regularly now that I have a permanent APO address.

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Major L. R. Ayers, former member of the staff at Pinecrest Sanitarium, Beckley, has been transferred from the Army Air Field at Camp Campbell, Kentucky, to the Hq. 74th TRG., Army Air Base, at De Ridder, La.

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Captain Robert R. Frye of Mannington, who has been stationed at Fort Bragg, North Carolina, is now serving with the armed forces overseas.

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Lieutenant Marcus E. Farrel (MC), USNR, has been transferred from the Naval Medical School at Bethesda, Maryland, to Epidemiology Unit No. 12, N.T.C., at Sampson, New York.

Major L. E. Nolan, MC, of Montgomery, Chief of Laboratory Service at the Station Hospital at Fort Sill, Oklahoma

Major Fred E. Brammer of Dehue, formerly assigned to a station hospital in the Caribbean area, but now commanding officer of a station hospital in South America, recommends that doctors read Dr. Clarence A. Mills' book, "Climate Makes the Man."

"While stationed at San Juan, Puerto Rico," he writes, "a certain army officer asked me if I had read the book, 'Climate Makes the Man,' which he said was written by a Cincinnati doctor. I told him that I had not read the book or even heard of it, but that I was curious to find out who the author was. The next day I went to the library to get the book and found that it was written by Dr. Clarence A. Mills, of the University of Cincinnati, who was a student there while I was in school, and whom I knew quite well.

"Since so many of our troops are stationed in the tropics in various parts of the world, I think even the folks back home are more 'tropics conscious' than ever before, and I recommend to them the reading of this book. It is published by Harper Bros., New York and Boston."

* * * *

Lt. Comdr. J. O. Rankin, of Wheeling, who has been serving as chief of the orthopedic department at the U. S. Naval Hospital at Memphis, Tenn., has been made chief of surgery at the same hospital.

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Doctor Clarence H. Boso, of Huntington, who has been stationed at the Regional Hospital at Camp Barkeley, Kentucky, for several months has been promoted to the rank of Captain.

* * * *

Captain Leonard M. Eckmann, of South Charleston, who has been with an AAA battalion in England, has moved on into France, and writes concerning life as he found it there early in August:

2 August, 1944.

My dear Mr. Lively:

Life is a bit more primitive here in France than it was in England, but it is surprising how a little ingenuity can make it fairly comfortable to live in an apple orchard. We're living in dug-in and sand-bagged pup tents. Already many of the men have constructed themselves underground residences that almost might be considered palatial. Supplies are adequate and food excellent,—far better than I expected.

There are a lot of refugees from battle areas who have come to the region guarded by my battalion. At first I thought the kids were stunted, possibly by lack of sufficient food during the Nazi occupation. But, it seems that a large number of the natives here are naturally very small. The farmers who live here are quite well fed and their livestock and crops are in first class condition, but the refugees are crowded together in large numbers in vacated or damaged buildings, and their lot, while not too bad, is not

the best. The nearest civilian doctor lives seven or eight miles away, and the only way they can get to him is on foot. Consequently, the medical officers do a bit of civilian practice.

The dental officer with me has extracted teeth and today opened an abscess. The only pay we'll take is in fresh eggs. I've sutured French scalps and done quite a bit of varied pediatric practice.

Today I saw three kids in one family with the worst cases of impetigo I've ever seen. Each one has any textbook picture beaten a mile, hands, arms, faces, ears, scalps, all manner of crusts and oozing lesions present for two months. My first medication was two big bars of G. I. soap. They have none at all, so the soldiers share a lot of their soap with the population.

Our cigarettes and candy have flooded the area. Uncle Sam gives each soldier a pack of cigarettes and a bit of candy each day. Already I've treated a couple of kids for tummy aches from too much "bon bons." They like our "shewing" gum, and some of the French kids have been taught to emulate their British brethren and will ask, "any goom, choom?".

All the kids smoke. They'll come up and ask, "Cigarette for papa?", and when you give them some for the old man, they'll take a few steps and then light up themselves and puff away. The best yet was a husky four-year-old, a girl, who lights her own cigarette and inhales like a veteran.

I haven't mentioned much in a military way, but we certainly know that there's a war going on here.

Sincerely,

Leonard M. Eckmann.

RICE DIET IN HIGH BLOOD PRESSURE

Much attention is being attracted by the report of a diet that seems to help patients with high blood pressure and kidney disease.

Dr. Walter Kempner of Duke University, developed the diet and reported it to the American Medical Association. It consists solely of rice, fruit juices, sugar, vitamins and iron.

Dr. Kempner's theory is that one of the kidney's functions, that of deaminating the amino acids of protein, is disturbed by lowered oxygen supply and the result is high blood pressure. The rice diet was developed to reduce the amount of protein the kidneys have to handle and thus lower the amount of harmful, abnormal substances which he believes causes the high blood pressure.

Not all patients benefit from the diet, though no ill effects from it have been seen. Blood pressures were reduced in about 60 percent of the patients, he said. The diet, like that for diabetes, must be prescribed individually for each patient so far as amounts of rice and the other ingredients are concerned.

One nutrition authority listening to the discussion on whether the patients would be gettting dangerously little protein from the diet, pointed out that the protein in rice differs from that in other cereals. —*Science News Letter.*

County Society News

CENTRAL WEST VIRGINIA

Dr. J. E. Offner, State Health Commissioner, was the guest speaker at the regular meeting of the Central Medical Society, held at Summersville, July 28. He spoke on the subject of Penicillin and discussed its use in the treatment of syphilis and other infectious diseases. A round table discussion followed, led by Dr. E. S. Brown, who served as chairman. The meeting was attended by over thirty members and guests.

Dr. J. L. Leef, of Richwood, was elected a member of the Society.

J. M. COFER, M.D.,
Secretary.

POTOMAC VALLEY

The annual summer outing of the Potomac Valley Medical Society was held July 26 at the camp of Dr. Thomas Bess, located in the Youghiogheny Forest. The meeting was attended by a large number of members and guests.

E. A. COURRIER, M.D.,
Secretary.

CONVERSION AND REHABILITATION

Conversion from war employment to peace-time employment for the able-bodied is going to be a gigantic problem, but for the handicapped it will be unsolvable unless we lay plans at once and unless we all work toward the same end. It is not a problem that is solved through sympathy and charity, but one that must be met realistically and with crystal clear vision. . . .

Everyone is now talking and thinking about rehabilitation. We are undergoing a time when there is a great need for the various federal, state, and local agencies in this field to be coordinated. There is very apt to be great duplication of effort and great confusion on the part of the handicapped unless all of us know just what the other agency is doing, just who they are interested in rehabilitating, and how far they may go. Almost all these agencies are using public funds, and the taxpayer is entitled to know where the money goes and just exactly for what purpose.—*National Rehabilitation News.*

Woman's Auxiliary

ANNUAL MEETING AT CLARKSBURG

The twenty-first annual meeting of the woman's Auxiliary to the State Medical Association will be held conjointly with the West Virginia State Medical Association's 78th annual meeting, at Clarksburg, May 14-15, 1945. Mrs. S. A. Ford, of Beckley, the president has announced that headquarters will be established at the Stonewall Jackson Hotel where all meetings will be held.

Mrs. W. E. Hoffman, of Charleston, is the state program chairman, and plans for the Clarksburg meeting will be completed early in the winter.

EXECUTIVE BOARD TO MEET

A meeting of the executive board of the Woman's Auxiliary to the West Virginia State Medical Association has been called by the president, Mrs. S. A. Ford, of Beckley, for October 3, at the Daniel Boone Hotel, Charleston, at 10 A. M. The business session will be followed by a luncheon at which Mrs. Luther H. Kice, of Garden City, Long Island, N. Y., national chairman on legislation of the Woman's Auxiliary to the American Medical Association, will be the speaker. Besides Mrs. Kice, the members of the auxiliary's advisory board will be honor guests.

LAST RESORT

The point for congressmen and all others who dream of a millenium to remember is this: government sickness insurance is a measure of last resort. It is suitable only when the great majority of people are getting very poor medical service or none at all and the social economy is such that it is impossible for them to provide anything better for themselves.

Our present system of medicine in America is admittedly not perfect. It needs improvement at many points. But it is better than anything available anywhere else in the world and the health of the people is the best of any comparable group in the world.

Furthermore, the vast majority of the people are able to provide it for themselves and theirs is the money that keeps it going. So long as that is the case, it makes little difference whether they spread the costs by insurance or develop some other methods of easing payments.—*Minnesota Medicine.*

Obituaries

CHARLES MATTHEW SCOTT, M.D.

Dr. Charles Matthew Scott, of Bluefield, founder and head of St. Luke's Hospital, that city, died August 7, 1944, at Iowa State University Hospital, Iowa City. The immediate cause of death was pneumonia, which followed an operation. He had been in declining health for the past six months. He was one of the outstanding physicians and surgeons of West Virginia and had practiced his profession at Bluefield for the past 40 years.

Charles Matthew Scott, M.D.

Doctor Scott was born in Tazewell County, Virginia, near the Mercer County border, October 31, 1878. When he was still quite young, his parents moved to Princeton. He was educated in the public schools of that city and enrolled at West Virginia University. He took his premedical work at Richmond College and graudated at the Medical College of Virginia in 1901.

After studying in Europe for a year, he returned to this country and located at Bluefield where he

was first associated with Drs. J. Francke Fox, Wade H. St. Clair, and the late Thomas E. Peery, as members of the staff of the old Bluefield Sanitarium. He built St. Luke's Hospital, naming it for St. Luke's at Richmond, on account of his love and admiration for Dr. Hunter McGuire. Soon afterwards, he established the St. Luke's Nurses Training School, from which hundreds of nurses have been graduated.

In 1924, the new St. Luke's Hospital was occupied, and it is today one of the most successfully operated hospitals in the state.

In 1908, Dr. Scott was married to Hazel Morton of Catlettsburg, Kentucky. Besides his wife, he is survived by two children, Mrs. Lewis C. Tierney, of Bluefield, and Dr. Charles M. Scott, who has just completed his basic training at Carlisle Barracks, Pa., and has been commissioned a lieutenant in the Army Medical Corps.

Doctor Scott was a member of the Baptist Church and was prominently identified with civic affairs in his home community. He served as secretary of the State Board of Examiners for Nurses for eight years, and was a charter West Virginia member of the American College of Surgeons. He was a member of his local medical society, the State Medical Association, and the American Medical Association.

EVOLUTION IN MEDICINE

Medical education began in Europe in the monasteries, then was fostered in the universities; its growth was hindered by superstition and obstructed by laws based on tradition; its tempo of growth became more and more rapid until the present time. The twentieth century has been marked in this country by reforms in the method and content of medical education and the close affiliation of medicine with ancillary science. With this marvelous advance has come a corresponding reduction in mortality from disease and a notable increase in life expectancy. The improvements in medical education and increase in medical knowledge in the past forty years are directly reflected in the increased efficiency of medical care of our military sick and wounded. The whole story of medicine in this country is that of an orderly evolution unrestricted by regimentation or federal interference.—*Ernest E. Irons, M.D., in J. A. M. A., July 29, 1944.*

Book Reviews

QUICK REFERENCE BOOK FOR MEDICINE AND SURGERY— George E. Rehberger, M.D. Twelfth Edition, 1944. J. B. Lippincott Company, Philadelphia. 1460 pages. Illustrated. $15.00.

The usefulness of this work is indicated by the fact that it has now gone through twelve editions in twenty-five years. The aim has been to make a "selection of all that is useful and needful in bedside therapeutics" and to have it "immediately available for practical needs." The material is arranged in eleven parts, under the ten headings of General Medicine and Surgery, Gynecology, Genito-urinary Diseases, Obsetrics, Skin Diseases, Eye Diseases, Ear Diseases, Nose Diseases, Throat Diseases, Orthopedics, and an eleventh part consisting of miscellaneous topics, which includes a list of drugs, the administration of anesthetics, metric and apothecaries' equivalents, etc.

Diseases and many symptoms are arranged alphabetically under each heading with abundant cross references, so that most subjects can be found quickly without using the index. In discussing diagnosis and treatments, methods of use of special equipment are described briefly and well. The description of technique of examination and treatment is extensive and valuable.

The present revision appears to be a thoroughgoing one. As might be expected in such a compendium, some of the more recent advances in therapy have occurred since the work of revision on that section was finished; sulfapyridine is discussed as the drug of choice in lobar pneumonia, with sulfathiazole and sulfadiazine mentioned casually, as new and useful but not emphasized. However, it may be noted that the use of these drugs, and of penicillin also, is considered in the section on drugs, even though not emphasized or mentioned in some of their frequent uses.

Part II consists of a description of the dosage, uses, toxicity etc., of the drugs recommended in the text. The coverage appears to be very complete; of drugs mentioned in the text atabrine is the only one noted to be absent in the section on drugs. There is some unnecessary repetition; identical descriptions are given under Aspirin, Acidum acetylsalicylicum, and Acetylsalicylicum, acidum. The tendency to describe official drugs under the proprietary name, or under a little used synonym, is

unfortunate. Descriptions are found under Acidum Diaethylbarbituricum and under Veronalum, but not under Barbitalium; phenobarbital and phenobarbital-sodium are described under luminal and luminal-sodium. In addition, the almost exclusive use of the apothecaries' system is regrettable. The number of entries in this section is very large; many of the drugs mentioned are obsolete or of questionable value.

In conclusion, it may be said that this work is monumental in its aim and does succeed in accomplishing its purpose to a remarkable degree. It is a valuable store of information for the physician confronted by the unusual or difficult in diagnosis or therapy. The information is readily and quickly available in an easily understandable form. The index is adequate but, is seldom needed, as mentioned above, because of the elaborate system of cross references. The book can be recommended as useful to the general practitioner when used with mature judgment.—J. J. Lawless, M. D.

METASTASES—Malford W. Thewlis, M.D., Attending Specialist, General Medicine, U. S. Public Health Hospitals, New York City. 217 pages. 13 illustrations. Charlotte Medical Press, Charlotte, North Carolina, 1944. $5.00.

This book is written in concise and outline form. It gives at a glance (a) the site of the primary focus (b) the sources of metastases and (c) the location of the metastases. It includes briefly an historical account and general consideration of metastases such as their soil, spread, pain and recurrences. It contains chapters on the metastases of neoplasms, infections, infectious diseases, emboli, leucemia, etc. There is also a chapter on regional metastases. Thirteen diagrams of lymphatics showing possible spread of neoplasms and abscesses are included. A very inclusive bibliography is added.

The book is valuable for busy surgeons, interns, roentgenologists, pathologists and students of disease who are anxious to obtain very quickly the possible primary sites of the lesions which they encounter.—C. C. Fenton, M.D.

POLIOMYELITIS—The Relation of Neurotropic Streptococci to Epidemic and Experimental Poliomyelitis and Poliomyelitis Virus, Diagnostic Serologic Tests and Serum Treatment—Edward C. Rosenow, M.D., Professor of Experimental Bacteriology, University of Minnesota, Mayo Foundation, Rochester, Minnesota. The International Bulletin, 319 West 103rd Street, New York City, Vol. A-44, 1944. 87 pages. Illustrated. $2.75.

This monograph summarizes nearly three decades of study during which the author has sought

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to demonstrate the streptococcic etiology of poliomyelitis. He grants its virus causation, as the term virus is now understood, but adduces evidence to support his thesis of the production of a transmissible, filtrable agent by neurotropic streptococci isolated from epidemic poliomyelitis. This agent has the properties of "natural virus."

A specific streptococcus was demonstrated consistently in the nasopharynx, stools, brain, cord and spinal fluid of epidemic human cases and of monkeys dying from experimental inoculations. It was found also in milk, water, mosquitoes, flies and in the air. Its specificity is indicated by (1) animal inoculation with living and dead streptococci, (2) by cataphoresis, (3) by precipitation and agglutination tests, (4) by skin sensitization tests, (5) by immunization of monkeys against the virus with suspensions of live and dead streptococci, (6) by neutralization of the virus and by creative action of the streptococus antiserum in epidemic and experimental poliomyelitis.

The specific streptococcus was absent from the nasopharynx of healthy persons, but was present in the nasopharynx and feces of practically all cases and was found commonly in healthy contacts.

Skin tests with fresh suspensions of the streptococci showed (1) positive reactions in virtually all cases at onset, with negative reactions upon recovery; (2) incidence of positive reactors roughly proportional to the incidence of the disease and to its age distribution; (3) rapid decline in incidence of positive reactors following the epidemic, which decline was greater in males than in females; (4) in cases with strong skin reactions the injection of streptococcus vaccine eliminated the skin reactivity and the serum acquired virus neutralizing power.

Precipitation for the specific streptococci was demonstrated in the serum of acute human cases and of monkeys, and it was still present during convalescence. It was not found present in the serum of healthy humans or of monkeys. Skin sensitization tests supported the thesis of the streptococcic etiology; the evidence and interpretation is too extensive for brief evaluation.

Antisera prepared with the poliomyelitis streptococci protected rabbits against the streptococcus and monkeys against the virus. Fresh antiserum neutralized the virus and old refrigerated antiserum showed marked therapeutic action against epidemic and experimental poliomyelitis.

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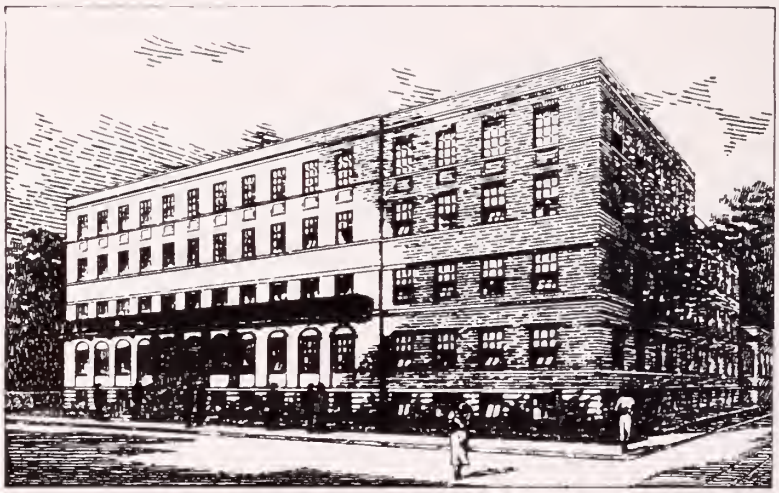

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From the available data epidemic poliomyelitis may be considered due primarily to a specific streptococcus infection, during which a filtrable viral phase develops. The filtrable phase was demonstrable also in vitro, under anaerobic conditions, in various enriched tissue mediums.

The streptococci phase is regarded as responsible for the early acute febrile and paralytic phenomena, while the later stage of lymphocytic infiltration of the spinal cord is attributed to the viral or "survival" phase of the streptococci.

The study concludes with a useful and extensive bibliography.—Robb Spalding Spray, Ph. D.

PARAMOUNT POST-WAR PROBLEMS

After the war is over there probably will be an urge to spend millions for building roads, for erecting fine and expensive buildings, and for granite or marble memorials to our soldiers who have died in the defense of our country. This must not be done at the expense of human needs. We cannot afford the very thing that has brought about the present revolution.

As soon as the fighting is over we should take into immediate consideration the paramount importance of health and medical care. Tuberculosis must be wiped out; venereal disease controlled; and mothers and babies given better care. The appalling number of mental breakdowns must be reduced. Medical care must be more adequately distributed. We cannot turn a deaf ear to all these vital needs.—*T. F. Abercrombie, M.D., in J. Med. Assn. of Georgia.*

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At least, in personal loans about 22 out of every 100 of us have to borrow to meet doctor, dentist and hospital bills. But less than one in a hundred causes financial trouble when he dies. That's how we stack up in the 1943 accounts of one of our largest lending companies.

Of the nearly one million financial advances made by that company last year, 22.5 per cent went to pay medical bills. Less than one per cent for funeral expenses.

More than 14 per cent of all individual borrowings were to pay taxes, which came next to doctor bills. The third reason was "overdue bills."

With all our faults, we're "good to our mothers." More than 61,000 successful applicants planned to help out their families—far ahead of the 53,000 who wanted money for travel and vacation expenses, 47,000 for "money making opportunities," 44,800 for clothing and 36,300 for furniture.

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NEW ILLNESS RESEMBLES APPENDICITIS

Capt. Butsch and Lt. Col. Harberson of the Army Medical Corps report a new illness which resembles acute appendicitis. Tentatively they believe that the cause may be a virus which affects local nerve endings. Location of the pain is about the same as in appendicitis, and nausea and vomiting occur, although some other symptoms are not similar. Pain becomes localized early, the face becomes brick red, and the soft palate is covered with a raised plaque of swollen mucous membrane of salmon pink color. Pain is worse at night and when patient lies down. Coughing, flexing the neck, or sitting up with knees extended increases pain. There is tenderness over the course of the nerves in the abdomen, and white blood count is not raised. Diagnosis is difficult and the doctors warn that appendicitis should not be discounted too quickly.—*R. N.*

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DOCTORS SHOULD SOLVE PROBLEM

It is a fact that in most sections of the United States any man, woman or child who seeks it can get good medical care in case of need, and that better care is available for the sick poor than anywhere else on the face of the globe today. It is also a fact that the cost of good medical service has mounted greatly in the last fifty years and that people of small income are often deterred from getting all of the care we would like to give them because the costs are too high. We know that here, too, the fault does not lie with the individual doctor. But no good will come from denying the fact that the problem exists. It is a problem which we, as doctors, should be the first to endeavor to solve.—*E. Mendelssohn Jones, M.D., in Minnesota Medicine.*

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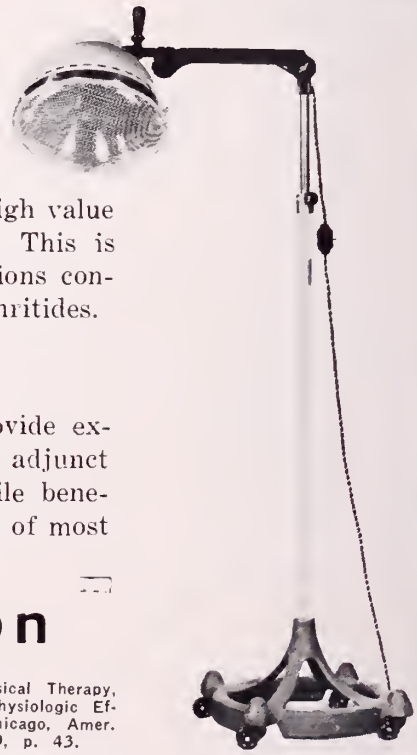

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*Handbook of Physical Therapy, Pemberton, R.: Physiologic Effects of Heat, Chicago, Amer. Med. Assoc., 1939, p. 43.

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WHAT IS THE MATTER WITH THE PATIENT WHO IS ALWAYS TIRED?*

By WALTER C. ALVAREZ, M. D.
Division of Medicine, Mayo Clinic
Rochester, Minnesota

I SUPPOSE one who has been interested most of his life in digestive diseases ought to be talking about some gastro-intestinal problem, but actually one in four or five of the patients I see complains mainly of fatigue. These persons are tired out, they have no pep, they have to drive themselves to work, and many think that if I would only go over them and find something wrong with stomach, or bowel, or liver, or something, I could fix them up and make them happy again.

A woman will say she is dragging around, unhappy because she cannot go out with her husband; she cannot be a good pal for him, and cannot be a good mother for her children. A young woman, perhaps a school teacher, is so tired that on Saturday she has to go to bed and stay there through much of Sunday; she has to live the life of a hermit; she cannot go out in the evening and be fit to work the next day. All such people want to be made stronger, and they hope desperately that I will find some focal cause for their trouble, something that I can tinker at or cut out. Unfortunately, many of us doctors have the same hope; we too have the idea that if we would examine thoroughly enough we would always find a focal cause for the disability, and in attempting to do this, and to satisfy the patient, we often keep grasping at diagnostic straws.

Every day I see tired persons who have been through several overhaulings and have been told that the cause of their troubles has been found in a dropped stomach, or a spastic colon, or gastritis, but usually these diagnoses have failed to help the situation and they look to me like placebos. Sometimes, of course, we physicians find something that is definitely wrong, like amebas in the stool, but even then we will not have uncovered the "cause," as shown by the fact that after

THE AUTHOR

Dr. Alvarez, graduate Stanford Medical School; Professor of Medicine, University of Minnesota Graduate School of Medicine; editor of Gastroenterology; past president, American Gastroenterological Association; author of texts and articles.

*Presented before the seventy-seventh annual meeting of the West Virginia State Medical Association, at Wheeling, West Virginia, May 15, 1944.

the parasites are all killed with drugs the patient goes on just as miserable as he or she was before. As I say, the amebas were parasites and it was good to get rid of them, but they were doing the patient about as much harm as so many fleas. There were not enough of them, and they were not causing the symptoms complained of.

Often we explore the abdomen and take out an appendix, or maybe a gallbladder that empties a little slowly; we take out teeth and tonsils, we give a lot of "shots," and what happens? The patient goes to another clinic and gets overhauled all over again. She pays another good-sized fee, she gets another placebo of diagnosis, and she has some treatment for this. Later she goes to another clinic and all is done over again, regardless of the fact that most of these persons can ill afford the great expense, and most physicians can ill afford to waste the time. With the best of intentions, we of the medical profession are evidently giving many of our tired patients a raw deal; we are not giving them much for their money, and worse yet, too often in our desperate efforts to help them, we hurt them. Whenever we perform a futile operation on some nervous, frail little woman, who can ill afford to pay even the hospital expenses, we have not practiced good medicine.

LESION NOT CAUSE OF FATIGUE

Although each year I examine hundreds of these tired people, and have made a lifelong study of their problems, I must admit that I seldom can find any focal cause for their distresses. I just cannot do it, even with all the fine laboratory and roentgenologic and other facilities that are at my disposal. And oftentimes, when I do find a condition which might be an indication for surgical intervention I do not want to advise it because I am so sure that the symptoms are not due to the condition and that operative treatment will not make the person well.

The other day I saw a woman with a myomatous uterus which she thought was causing all of her ill health and abdominal discomfort. It may well have had some part in doing this, but I doubt now if I would have let her undergo a hysterectomy when I did if I had learned sooner that her husband had recently taken to drinking so heavily that he was facing dismissal from his position, and utter ruin. No wonder the poor wife, wrestling night after night with this problem, was tired out and unable to rest or sleep.

I could tell innumerable such stories to show how often the lesion found is not the cause of the fatigue. In many cases I think most of you would agree with me, after reviewing the record, that the diagnosis that the tired person came with was not significant; the finding may have been all right, but it was not causing the illness and it could not explain all the symptoms.

EXAMINATION NOT NECESSARY

Commonly, when one of these nervous, tired persons comes in, asking for an extensive overhauling and hoping desperately that at last I am going to find the cause of her trouble, I rather hate to start examining her; I would rather start preparing her for the disappointment which I am pretty sure will come at the end of the study. A physician said to me a few minutes ago, "I wish you would talk to us on the problem of dismissing a 'neuro'; of telling her that she is a 'neuro' and getting away with it; of satisfying her, of getting her to mend her ways, and of keeping her from going straight off to some one else for another examination." Yes, that is one of my biggest problems. Many times I say to these people, "I wish you hadn't come. If only I had seen you in your home town and had talked with you and your wise old family doctor for five minutes, I would have said, 'Your doctors here have examined you well. They have told you that they cannot find anything significant; they have told you that you are chronically frail and ailing like your mother before you. I think they are right; and under the circumstances you must not expect me to work any miracles of healing for you. Why now waste more money on a repetition of all the old tests?' "

But these people usually come anyway. They say, "Go ahead and give me a more thorough examination than I ever had before. If you'll only look hard enough and long enough you'll find the cause of my trouble."

I often wish they would give me credit for knowing something about disease and sick people. As I often say, "For thirty-five years I've been studying people like you every day, and surely, by now, I ought to know something about you. I ought to be able to recognize you and your troubles at a glance—I do, and this problem of yours is nothing new or puzzling to me."

We physicians can have the abdomens of these people explored surgically without finding anything significantly wrong. I remember a man who for twelve years had what appeared to be a psychoneurotic pain in the right upper quadrant of his abdomen. Every year he came back and insisted upon having another examination. Finally he talked a surgeon into performing an exploratory operation, and nothing was found. My assistant said, "Probably the surgeon missed the cause." But eventually the man died of a stroke, and when a complete and careful necropsy was performed, again, no cause could be found for the pain. Actually there should be many types of pain for which we cannot hope to find any macroscopic cause. I think the pain is real, but the cause will never be seen with the naked eye. It may not be in the place where the hurt is; often, probably, it is up in the brain, and the distress is referred out to the periphery.

CHARACTERISTICS OF FATIGUE OF PSYCHIC ORIGIN

Often one can tell right off that a person's fatigue is due purely to a nervous inheritance. Characteristically, this type of distress is present in the morning; the patient wakes with it and it wears off gradually in the late afternoon. Particularly when a person has a neurotic ancestry, there may be days when he will wake feeling so depressed and miserable that he will wonder how he can find strength to get up and face the day. About three or four o'clock in the afternoon he will begin to feel better, and about ten o'clock at night he may feel like "going places." Obviously, such fatigue is not due to a hard day's work. If it were, it would most likely come at night and would not be such a bruising and punishing type of fatigue. Significant is the fact that in many instances the woman with the terrible type of morning fatigue has no work to make her tired.

Sometimes, in trying to get these patients to see that just from their story and appearance I should know much about them and their disease, I say, "Suppose we were to hear a child cough in a particularly harsh and brassy way, and then whoop and vomit. Couldn't you make the diagnosis?"

"Surely," says a mother of several children, "whooping cough."

"Correct, and you wouldn't feel then that you had to take the child's sputum to the laboratory for the isolation of the bacillus of pertussis, and you wouldn't need to roentgenograph its lungs; you would just know it had whooping cough." Well, when a frail little woman comes in, perhaps with a history of five abdominal operations, none of which did much good, and many complaints of fatigue, aches and pains everywhere, dysmenorrhea, and what not, I do not have much desire to examine her. I have been in the game long enough to know that I am not going to work any miracles for her. Even if I were to find a tumor as big as a child's head, and remove it, I would not work a cure.

PSYCHOPATHIC INHERITANCE

Often the person with painful fatigue has a bad psychic inheritance. To illustrate: One day I saw, in consultation, a woman forty-five years of age who had the very distressing type of morning fatigue. She had been examined many times by competent men, but nothing significant had been found. She had a good husband, good servants, no overwork, and no cause for unhappiness or strain. I asked just one question: "Which of your near relatives had a bad nervous breakdown?"

She said, "My mother went insane when I was born."

Now, to my way of thinking, this fact explained everything. Her distressing fatigue represented a mild equivalent of her mother's melancholia. I feel sure of it because I have heard this story and seen this association so many times.

Some of you may ask, "But can't you find a history of insanity in almost any family?" No, I cannot find it in the families of most sensible healthy people, but I can find it commonly in the families of the patients with constitutional inadequacy and a pathologic type of fatigue. To be true, insane ancestry must be common because insanity is so common. There probably is a child being born right now in this city, and do you know what its chances are of being committed some day to a state asylum for the insane, the feeble-minded, or the epileptic? The chances are one in nineteen! Think now of the added number of incompetent persons who are cared for in homes, constituting a terrible problem to their relatives, and think of the number of queer relatives each one has, all slightly tarred by this same brush. It is one of the biggest problems facing civilization today.

RELATIVES OF THE INSANE

One of the commonest diagnoses that I make in the office every day is "relative of the insane." Some of you may think it a bit queer, but really it is a most helpful and instructive diagnosis. Often it tells me all I need to know about the etiology of a bad hypochondriasis or psychoneurosis in a person who would like to take up all of my day with a recital of his symptoms.

Many of the tired people I see each day are constitutionally inadequate. I think they will always be somewhat frail and sickly. They cannot be made over. When they say to me, "Surely there must be some way in which I can be cured," I reply, "Yes, but the only way I know of would be to begin with a different set of grandparents."

Some doctors say, "Do you mean to tell me that you tell patients that they are hopelessly inadequate? Isn't that terribly discouraging?"

Yes, but often I soften the blow and get them to see what I mean by admitting that to some extent I, too, am constitutionally inadequate. I could not earn my living as a prize fighter or a wrestler. I found once that I could not even stand the long hours and loss of sleep that a busy general practitioner has to endure day after day. I tried it, and found that I could not "stand the gaff;" I had to become an internist who could go home at 5:30. I do not tell these people that they must be a failure in life; what I ask is that they do as I did, and try to find a job within their means of strength. I ask also that they learn to hoard their energies and not to fritter them away on emotional debauches, as so many people do.

OTHER CAUSES OF FATIGUE

Many tired women are tired because they are so unhappy and so full of worries. Many are unhappily married; perhaps with an alcoholic, or a gambler, or a chaser, or just an inarticulate person for a husband. Many cannot get a divorce because of children or financial responsibilities or frail health. We physicians must get these stories and must help these poor women to adjust to their problems as best they can. Sometimes they regain their health when they are made to see that they just cannot get out of their bed, no matter how unhappy it is, and hence they had better stop thinking of divorce and settle down to make a better go of marriage.

If a patient who comes complaining of fatigue never was worth the powder to blow him up, if he never amounted to a hill of beans, and if he comes of a "poor trash" tribe, most of whom never stuck to a job, I am not so concerned over the diagnosis, but still I am willing to give the man one good examination. A "neuro" *can* have organic disease. But if a man who has always worked hard and felt well suddenly starts to crack, then I want to go over him most carefully and I want to keep going over him until I am sat-

isfied that there is nothing wrong besides overwork.

In such cases a test that helps me much is the estimation of the blood sedimentation rate. Many a time I have had a patient referred to me with the diagnosis of a neurosis, and perhaps at first glance have been much inclined to agree, but when the laboratory reported a sedimentation rate of perhaps 75 or 100 mm. in an hour (Westergren), I settled down to make a most careful examination. In all but a few such cases I have been able to find a serious lesion. In puzzling cases of this type I often order a liver function test, and if the report comes back "dye retention grade 3 or 4" I suspect that the liver is full of metastatic nodules, and then I have the roentgenologist and proctologist study the bowel with the greatest care.

In young people, of course, I look for tuberculosis, and I always have a film made of the chest. Sometimes a college student who has been doing well in his studies, suddenly, after having had one or two vomiting spells or a bad stomachache, will become tired and "pepless" and unable to work. Sometimes, then, it will be found that he has a smouldering appendicitis.

HYPERTENSION BEGINS IN YOUTH

Hypertension usually begins in youth and often makes the victim a bit tired and worried about his health. Hyperthyroidism, hypothyroidism and heart disease are less common causes for a fatigue state. Often an attack of influenza will leave the patient tired for weeks or months, especially, perhaps, if there has been an encephalitic type of virus mixed up with it. A tendency to migraine will oftentimes go with a fatigue state.

In my opinion brucellosis is now a poor diagnosis to make. I see many persons with this diagnosis but I can rarely confirm it. Almost every patient who has come to me with this diagnosis has looked to me more like an ordinary "neuro" with occasionally an afternoon temperature of 99.5 F. I think this temperature is normal for most nervous women. In cases of suspected brucellosis I look at the spleen with the roentgen ray, and when I find it small, I seriously doubt the diagnosis. I also get a blood sedimentation rate and when it is under 10 mm. in an hour, I cannot believe that the patient has any smouldering infection.

One of the common causes of nervous breaks in older people is a small stroke which has not been big enough to affect the centers for an arm or a leg. Just think of the thousands of places in the brain where a small thrombosis can occur, just big enough to produce a dizzy spell, a little mental confusion, or a few symptoms of bulbar involvement. Some of these little strokes take away all the patient's joy in life, and perhaps the ability ever to work again.

NERVOUS BREAKDOWNS

Many of the people who come to me with complaints of indigestion really have a nervous breakdown, but they do not tell their history in such a way as to make this apparent. How does one recognize a nervous break? Only by asking a few essential questions. Curiously, able young assistants usually fail to find out the most important thing about a patient, namely, that he has not worked for one or more years. And, if they learn this, many do not think to ask why he does not work. If they had, he would probably have said, "I just can't face people. If I were to try to talk to a customer I would get jittery and have to excuse myself." Very helpful is the discovery that these people cannot read. By way of explanation, they say they are not interested enough, or the letters run together, or they forget a paragraph as soon as it is read. Often such a person cannot stand even listening to the radio, or going to a movie. At a movie he soon gets tense and has to go out. Some get overly emotional, and cry. They cannot make decisions at the office, and their work suffers. Usually they cannot sleep well at night. They are irritable and "fly off the handle" easily. Any person with such symptoms has, primarily, a nervous breakdown; his brain isn't working right.

The next question is: Why has he a nervous break? Was it caused by overwork, strain, worry, sorrow, insomnia, several operations, an automobile accident, or an attack of influenza? If so, and if the patient has a sane ancestry, his breakdown will probably be easily curable. The most dangerous type of nervous break is the one that comes out of a clear sky without any apparent cause in a person who has insane ancestry. Guard your prognosis in that type of case. Guard it also when, in the case of an older person, the break followed some sudden attack which may well have been due to a little stroke. Guard it when there is a history suggesting an attack of encephalitis. Too often the story of an attack of mild encephalitis is not drawn out by the many physicians who see the patient in later years, and so he gets treated for indigestion.

SUMMARY

Let us physicians not be so determined always to find an organic cause in the abdomen or thorax for a patient's sense of fatigue. Let us look for it oftenest in a tired brain or in a brain handicapped by poor nervous heredity. Let us constantly be on the watch for the symptoms of a nervous breakdown, and when such a break is recognized, let us find out why it came.

SKIN CLOSURE WITH PLAIN O SUTURE

(Preliminary Report)

By A. P. HUDGINS, M. D.,
Charleston, West Virginia

For many years the skin of operative wounds has been closed with skin clips or non-absorbable suture material and the routine use of retention sutures has become more or less a thing of the past.

The writer has found plain O gut suture very satisfactory for the closure of operative wounds. The advantages of this method of closure may be listed as follows: (1.) The skin may be rapidly closed by this method. (2.) The wound heals well with an acceptable appearance to the scar. (3.) Suture removing is eliminated.

To take these up in a little more detail: The speed of the closure of the wound should not, of course, be sacrificed if improper healing or other unsatisfactory elements result. But it is equally foolish to refuse to use a method which may reduce the operative time from five to eight minutes, when the end results are entirely satisfactory. Closing time of the skin can be reduced by the use of continuous O plain gut suture.

The cosmetic appearance of an abdominal wound is not, of course, the primary objective in considering such surgical procedure. It is true, however, that an unsightly wound can make certain patients, particularly women, very unhappy. Here again, if more important considerations are not neglected, this minor consideration might well be borne in mind in considering a certain technique.

THE AUTHOR

Dr. Hudgins, graduate Medical College of Virginia; Post-Graduate, Bellevue Hospital, and Post-Graduate Hospital, N. Y. C.; Obstetrics, Chicago Lying-In Hospital.

Suture removal is eliminated. Very frequently one finds that the patient dreads the removal of the sutures almost as much as the actual operation. If he can be told soon after the operation, that there are no sutures to be removed, the patient is made happier and the convalescence may run more smoothly without this sense of dread concerning the sixth, eighth or tenth day. A technique which obviates the necessity of suture removal is also a time saver: a consideration which should be borne in mind in these war times

when hospital staffs have been reduced. Fifteen minutes of the time of the nurse and house doctor—or of the attending physician—is saved when suture removal is unnecessary. There is also a saving in bandages and dressings, as there is no need for frequent changes under ordinary circumstances. There is also one other consideration which is not frequently found but which should be borne in mind; namely, the meddlesome tinkering with an operative wound which may take place if manipulation of the wound — or suture removal—is necessary during the post-operative course.

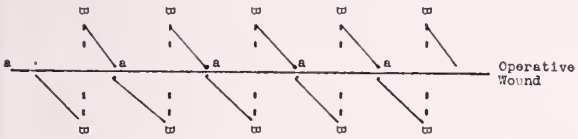

DIAGRAM OF WOUND SHOWING SPECIAL SUTURES
Sutures—superficial, through at skin edge (a); deep, from B to B; dotted line sutures under skin.

The following technique has been found by the author to be satisfactory and has been used in over 100 cases for skin closure in operative wounds on the abdomen; and 3 for the skin closure of breast wounds. The operative wounds include several potentially infected wounds such as those for acute appendicitis and low grade infections which were found in all pelvic inflammatory disease. In very obese patients, subcutaneous sutures were put in.

Technique for skin closure: The skin is put on tension by pulling the opposite ends of the wound, either with skin hooks or Allis forceps. It has also been found to be advantageous to put an Allis forcep at approximately the midline of the wound if it is longer than about three inches. A modified running mattress suture, using plain O gut, is then put in, using an alternate deep and superficial stitch as shown in the diagram. This particular type of suture technique seems to accomplish better skin approximation at the edges with less tendency to skin inversion or gaping. The opposite ends of the wound should be kept on tension at all times to keep the wound from being collapsed or pursed thus preventing a "purse string" effect.

During the early cases where this technique was used, when special care was not taken to keep the skin edges on tension, there was some superficial necrosis in two cases due to cutting off of the blood supply. This was not found to be true when the tightening of the sutures and tension on the wound were prevented. No other disadvantages were found which could be attributed to the technique or to the suture material used. Occasionally, there was a gaping of a very small area at the lower portion of the wound which was attributed to improper placing of the sutures. At times there was a slight serous drainage, but this was very infrequently encountered and could not be considered a result of the skin closure technique. There were no unsatisfactory results seen in the appearance of healing of the wound as a result of this serum because the O plain suture was used. There were no infections or stitch abscesses.

SUMMARY AND CONCLUSIONS

1. Number O plain gut suture has been found to be satisfactory for closure of the skin in operative wounds.

2. The advantages are: (1) speed in closure of skin wounds, (2) satisfactory cosmetic appearance of the wound, (3) suture removal eliminated, thus saving time for the hospital staff and physician and obviating the necessity of the dreaded procedure for the patient and (4) no unfavorable results which could be attributed to this method of skin closure.

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THE ROLE OF EXOPHTHALMOS IN THE DIAGNOSIS AND TREATMENT OF GRAVES' DISEASE*

(REPORT OF CASES)

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THE eye signs are among the earliest manifestations of Graves' disease, and their recognition is important for an early diagnosis. It is the purpose of this article to point out that they are also of value in determining the proper treatment, for they are helpful in separating those cases which do well under surgical treatment from those which do badly. The eye signs are familiar to everyone, and there is no need to call attention to the number which have been described. Attention has been focused chiefly on the excessive prominence of the eyes, from which the term exophthalmic goitre was derived. Under the heading of Graves' disease I include cases with the characteristic eye picture whether or not they are accompanied by thyrotoxicosis.

LID RETRACTION

While actual protrusion of the globe may and frequently does take place to a mild degree early in the disease, there is another sign which occurs earlier and which frequently gives rise to an appearance of exophthalmos of greater degree than that actually present. This sign consists in retraction of the upper lid, which causes a widening of the palpebral fissure resulting in the characteristic facial expression of thyrotoxicosis, i.e., the wild, staring appearance of the eyes, and the look of fright. It is called Dalrymple's sign. Nearly all of the other lid signs of Graves' disease, such as lidlag, infrequent winking, etc., are due to the lid retraction. It should be emphasized that bilateral lid retraction of itself gives rise to the appearance of exophthalmos; when it is unilateral it simulates a unilateral proptosis.

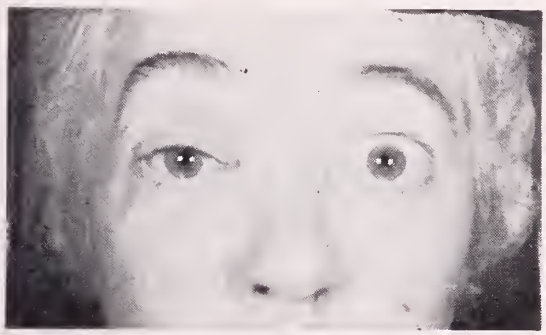
The cause of retraction of the upper lid in Graves' disease is not definitely known. Holloway and Fry[1] point out that Dalrymple naturally explained the retraction of the upper lid as being due to spasm of the levator palpebrae, as Müller's muscle had not at that time been discovered. They imply that the sign is really due to spasm of the involuntary muscle in the upper lid.

Elevation of the upper lid takes place by means of contraction of the levator palpebrae muscle, which is supplied by a branch of the third nerve. Attached to the under surface of this muscle, lying just beneath its aponeurosis, is a broad band of unstriated muscle supplied by the sympathetics, which is known as the superior palpebral involuntary muscle. It was first described by Müller in 1859, and hence is often called

*Presented before the seventy-seventh annual meeting of the West Virginia State Medical Association, at Wheeling, West Virginia, May 16, 1944.

by his name. It should not be confused with the Müller's muscle which lies on the floor of the orbit covering the inferior orbital fissure. According to Whitnall its fibers arise from between the striated fibers of the levator by elastic tendons, and have a similar mode of fixation to the upper margin of the tarsal plate.

The levator probably effects gross changes in the position of the upper lid voluntarily, whereas the maintenance of posture is involuntarily effected by means of the superior palpebral muscle. In third nerve paralysis the lid is drooped and the superior palpebral muscle cannot effect its elevation. In Horner's syndrome, due to paralysis of the superior cervical sympathetic, the lid is drooped causing a ptosis, but the lid can be voluntarily raised.



Lid retraction of left eye, no exophthalmos. Exophthalmometer reading 18 mm. in each eye with base line of 94.

The lid retraction is not due to paralysis of the orbicularis muscle supplied by the seventh nerve. The lid can be voluntarily closed, and there is no facial weakness.

The retraction of the upper lid in Graves' disease can be due to two causes: spasm of the levator muscle or spasm of the superior palpebral muscle. Most writers on the subject believe that it is caused by stimulation of the sympathetics, and yet as Means[2] points out, no other signs of superior cervical stimulation are to be found, such as dilation of the pupil on the affected side. Means[2] concludes that the sympathetic has little if anything to do with any of the ocular manifestations of Graves' disease.

Retraction of the upper lid is not pathognomonic of Graves' disease. Friedgood[3] called attention to this sign in cases of essential hypertension. Collier[1] found retraction of the upper lid associated with ophthalmoplegia in lesions of the upper brain stem in the region of the posterior commissure. In some of his cases of ophthalmoplegia there was lid retraction, whereas in others the lid was ptosed, and in one bilateral case there was lid retraction on one side and ptosis on the other. He concluded that lid retraction was a means of distinguishing supranuclear from nuclear lesions of the third nerve. In supranuclear lesions retraction of the upper lid was usually present (Collier called them tucked lids) whereas in nuclear lesions ptosis was the rule.

Collier[1] does not discuss the site of the lesion producing lid retraction in these cases, other than to imply that the fiber tracts concerned with the condition are located in the anterior part of the upper brain stem. He does not specify whether it is due to spasm of the levator or to spasm of the superior palpebral muscle.

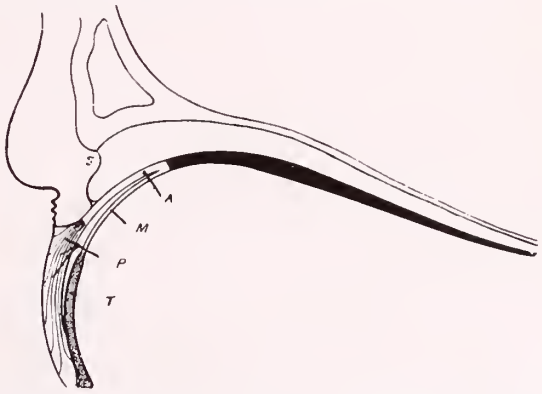


Diagram of insertion of the levator palpebrae muscle (From Whitnall's Anatomy of the Orbit—Oxford University Press).
A—Tendon of levator.
M—Tendon of Muller's muscle.
P—Insertion of levator in skin of lid.
T—Tarsus.

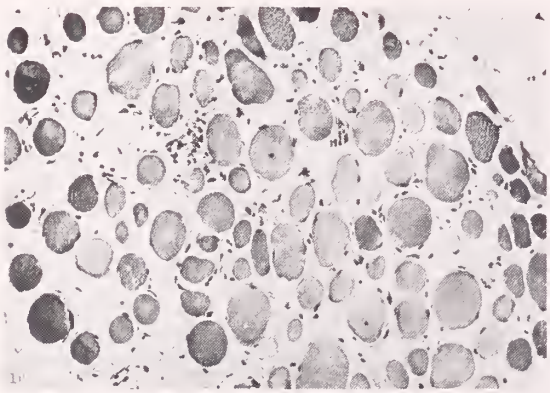
Spasm of the levator muscle associated with lesions of the third nerve has been described as the pseudoGraefe phenomenon, and it is thought by some to represent the growth of aberrant nerve fibers after recovery from a third nerve paralysis.

I have seen a number of cases of retraction of the upper lid presumably caused by spasm

of the levator in a variety of conditions, i.e., paralysis of the inferior oblique muscle on the opposite side (case 1), sphenoidal ridge meningioma, verified by operation (case 2), and several cases of Parkinsonism.

Bender[5] reported a case due to compression of the third nerve by a sphenoidal ridge osteochondroma. He suggested that the lack of associated movement of the upper lid with the eyeball on downward gaze (the von Graefe lid sign which always accompanies lid retraction and is caused by it) was due to a tonic innervation of the levator muscle. This tonic innervation, he believed, represented impulses intended for the orbicularis muscle which were shunted to the levator muscle.

Velhagen[6] described a group of cases of epidemic encephalitis with Parkinsonism with all the lid signs of Graves' disease and stated his belief that the retraction of the lids was due to increased tonus of the levator muscle. He made the suggestion that all of the eyelid signs of Graves' disease are due to toxic damage of tracts in the neighborhood of the third ventricle and the aqueduct of Sylvius, or of the motor ganglia in the brain stem.



Biopsy from case 10. Cross section of a piece of one of the ocular muscle fibers, showing separation by edema. There is beginning round cell infiltration.

He based this on the frequent occurrence of the same symptoms (presumably the lid signs) of Graves' disease in epidemic encephalitis which affects this region.

It is tempting to speculate on the cause of lid retraction as Velhagen has done, but until we have more definite evidence it is best to content ourselves with the fact that for some reason or other this mechanism is overstimulated early in Graves' disease and that it can occur in lesions in the upper brain stem. It occurs chiefly in the thyrotoxic cases but it may be seen in those in which the toxic symptoms are minimal and the exophthalmos is marked.

Marked edema of upper and lower lids. Exophthalmometer reading 24 in each eye with a base line of 108.

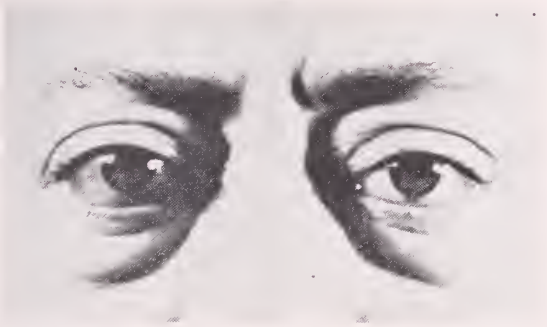
Exophthalmos can be determined only by actual measurement of the protrusion of the globe in the orbit, and even then one cannot be sure there is an abnormal prominence of the eyes unless (1) there is a difference between the two eyes of more than a millimeter and a half or (2) measurements taken over a period of time show unmistakable change in the position of the eyes. Unilateral exophthalmos or enophthalmos is therefore much easier to determine than bilateral.

The normal values for the protrusion of the eyes in different individuals have a wide range, and are given differently by different authors. Mainnini[7] gives 17.5 mm. as the upper limit of protrusion measured by the Luedde exophthalmometer, and Hymes[8] found a variation in normal males 22 years of age of from 11 to 19 mm., and in a similar age group of females of from 9 to 16 mm. In my own practice readings with a Hertel exophthalmometer run all the way from 13 to 26 mm. in normal individuals, and many of these higher values have been checked over a period of years, because of the suspicion that they might be pathologic, without showing any change.

These figures illustrate how difficult it is for anyone to say that an individual has bi-

lateral exophthalmos unless previous measurements, taken when the individual was well, have shown that an increase has occurred. It is very seldom that authors reporting cases of thyrotoxicosis have had an opportunity to do this.

A small degree of exophthalmos can be caused by retraction of the lids. In nearly all normal individuals voluntary widening of the fissures, as in mimicking fright, results in a measurable increase in protrusion of 1 mm. This is not due to relieving the weight of the upper lid from the globe, as raising the lid manually or by means of a speculum does not produce it. When the upper lid is held away from the globe, however, by means of a speculum and then an attempt is made to protrude the globe, very little, if any, protrusion occurs. It seems as though the pulling of the upper lid back into the orbit mechanically displaces the eyeball. Compression of the veins of the neck also causes about 1 mm. increase in protrusion. Dr. David Cogan found a protrusion of about 3 mm. in normal individuals during voluntary retraction of the lids, according to Means[2].



Swelling of both upper and lower lids with chemosis of the conjunctiva.

The reason there is so much diversity in opinion as to the pathogenesis of the exophthalmos in Graves' disease is the fact that there are really two different kinds of exophthalmos. One type which is generally seen in the severely toxic cases is due to the protrusion of the globes by the same mechanism which causes lid retraction. It disappears when the lid retraction leaves, either following successful treatment of the thyrotoxicosis, or in death. In these cases the orbital contents show no changes. It is seldom greater than 2 or 3 mm. proptosis, as the figures of Soley[9] show. This author was the first to call attention to the frequency with which clinicians confuse lid retraction with exophthalmos, and he sagely remarks, "The statement one hears so frequently that 'the eyes snapped back after the goitre was removed' means that the stare (due to lid retraction) disappeared." It usually does not mean that the eyeball protruded to a lesser degree."

Proptosis of the left eye. Exophthalmometer reading: O. D. 17, O. S. 25. Edema of both lids and chemosis of the conjunctiva left side. Paralysis upward gaze.

Soley[9] gives a distribution curve of the exophthalmometer measurements in normal persons and in patients with diffuse toxic goitre. The curve of normal persons runs from 12 to 21, with a mean at 16. The overlapping curve of the cases of toxic goitre runs from 12 to 24 with a mean at 18. It is true that 5 per cent of the measurements of normal persons were greater than 19, whereas 32 per cent of the toxic goitre cases were above this figure, but when one considers that the persons with toxic diffuse goitre are the ones in whom the greatest degree of exophthalmos is supposed to occur, it seems strikingly small in degree.

This contrasts sharply with the other type of exophthalmos. In these cases of hyperthyroidism very marked exophthalmos develops early and is relentlessly progressive, so that corneal ulceration occurs by exposure of the globe, and the eyes may be lost. This type of exophthalmos is quite different in its course and in its pathology from that which occurs in the typical case of Graves' disease.

It has been shown by a large number of clinicians that the exophthalmos in this instance is due to an edema of the orbital contents which, if sufficiently prolonged, leads to cellular infiltration, connective tissue proliferation, and permanent thickening of the orbital tissues. Dunnington[10] ascribes the condition to chronic orbital myositis. It does not disappear after death. If the individual is thyrotoxic, operation may reduce or cure his thyrotoxicosis, but the degree of exophthalmos attained remains the same or even becomes greater. This is particularly true if the patient has a total thyroidectomy.

DIFFERENT TYPES OF TREATMENT

These two types of exophthalmos have a different prognosis and must receive entirely different treatment. The one is of mild degree and occurs after definite symptoms of thyrotoxicosis have set in, and either stops after partial thyroidectomy, or perhaps, as Soley[9] has pointed out, may increase slightly for a time after operation and then may decrease slightly.

The other type, which is the one we wish to consider in detail, first came to the attention of the unfortunate thyroid surgeon who found to his dismay that certain cases of exophthalmos became fulminating after operation instead of getting better.

These cases have been called by many different names: progressive exophthalmos by the surgeons who precipitated them by surgery, malignant exophthalmos by the ophthalmologists who treated them unsuccessfully, exophthalmic opthalmoplegia by the neurologists whose chief interest was to differentiate them from myasthenia gravis and the ocular paralyses of typical Graves' disease. Their prototype has been produced in the laboratory and studied extensively by the injection of anterior pituitary extract in suitable animals. It is known that the exophthalmos is best produced in animals in which hypothyroidism is present as a result of a previous thyroidectomy. The pathological histology of the orbital contents in these animals is similar to that found in man.

Whatever name we apply to this particular type of exophthalmos, (Means calls it the special ophthalmopathic type, which is probably the best term coined so far) all who have seen and followed any of these cases are agreed that the best treatment is prevention, and that this is accomplished in the vast majority of cases by refraining from operation. An analysis of the cases in the literature shows that in most instances exophthalmos has occurred after the thyroidectomy.

How can we recognize this ophthalmopathic type of Graves' disease and prevent its occurrence? Since in the majority of cases in the past our attention has been called to them only when the condition became serious from the point of view of ocular damage, our experience is limited as to their onset, but we have now seen a sufficient number of cases in the early stage to be able to make suggestions as to how to identify them. This description may have to be modified after further experience.

EXOPTHTHALMOS COMES EARLY IN DISEASE

The earliest sign in these cases apparently is edema of the lids (case 3). In two cases this was the only physical finding. Along with edema of the lids there is usually edema of the bulbar conjunctiva. The palpebral conjunctiva is not edematous, but the fluid collects under the conjunctiva around the globe and settles down in the lower fornix. When this becomes marked the swollen conjunctiva protrudes between the lids when they are closed and, due to exposure, it becomes thickened, chronically inflamed, and adds to the unsightly appearance of these patients (case 4).

Exophthalmos, bilateral or unilateral, comes on very early in the course of the disease. In classic Graves' disease the exophthalmos follows symptoms of thyrotoxicosis. In the ophthalmopathic type exophthalmos precedes or even seems to replace the toxic symptoms. I have the impression that in general the cases of the ophthalmopathic type I have seen had very little thyrotoxicosis. The basal metabolic rates were uniformly com-

paratively low and in some cases definitely minus, as will be described. There was no loss of weight, tremor, nervousness or sweating all of which are so characteristic of classic Graves' disease.

The exophthalmos increases rapidly, and there may be a marked lid retraction so that the patient's eyes literally appear to be popping out of his head, and occasionally they have become herniated between the lids so that they had to be replaced.

Lid retraction does not occur in all cases, however. There may even be ptosis, and these cases are the ones in which myasthenia gravis may be an associated condition (case 10).

EXOPHTHALMIC OPHTHALMOPLEGIA

By the time the exophthalmos has reached a considerable degree the patient is unable to move his eyes normally, and in this stage he is considered as having a syndrome called by Brain[11] "exophthalmic ophthalmoplegia." It is doubtful if these patients should be considered to have a true ophthalmoplegia, for as Brain[11] himself admits, the condition is not a paresis or paralysis of individual muscles but of movement of the two eyes in a particular plane. The paralysis is not due to a lesion of the nerve paths by which these muscles are linked together, but is a mechanical effect of the exophthalmos (case 7). Brain[11] states that when the ophthalmoplegia is unilateral, elevation is the movement most often affected, and when both eyes exhibit ophthalmoplegia, abduction is the movement which suffers most often. The degree of weakness of an ocular movement is fairly constant from day to day and does not fluctuate.

The ophthalmoplegia is probably due to a rise of pressure within the muscle cone due to the edema and cellular infiltration. This same rise of pressure in the orbit leads to the progressive exophthalmos. Charpy[12] (quoted by Brain[11]) showed that injections of fluid inside the central part of the oribtal fat in the muscle cone caused both exophthalmos and immobility of the eye.

Brain[11] distinguishes these cases with the ophthalmopathic type of exophthalmos and consequent limitation of ocular movements from cases of myasthenia gravis which may occur in association with thyrotoxicosis. The distinguishing features are as follows: In myasthenia gravis, ptosis is extremely common, whereas it is very rare in the ophthalmopathic type. In myasthenia gravis the difficulties in ocular movements become worse towards the end of the day, whereas the other cases seldom exhibit fatigability of the affected muscles. The most valuable distinction, of course, lies in the difference in response to prostigmine. None of the cases of ophthalmopathic exophthalmos showed any improvement in the ocular rotations under prostigmine, according to Brain[11], whereas all of his cases of myasthenia gravis associated with thyrotoxicosis did show improvement.

In one of the cases reported in this paper the ophthalmopathic type was associated with myasthenia gravis, so that the two may occur simultaneously (case 10).

Choked disc may occur during the severe stage of the exophthalmos, and the visual acuity may be affected and visual field changes occur, usually in the form of central or paracentral scotomas.

EDEMA OF THE LIDS

The ophthalmopathic type of Graves' disease will probably first be seen by the ophthalmologist to whom the patient comes because of edema of the lids. At that time, however, the patient already may have begun to have exophthalmos. If this is unilateral an orbital tumor will probably be suspected. If the exophthalmos is bilateral, and especially if there is any lid retraction, a diagnosis of early Graves' disease will probably be made.

These are the patients who should not be operated on, but instead should be given thyroid extract if they have a low basal metabolic rate. The dosage given is that sufficient to produce a normal basal metabolic rate, and they are maintained on that. In addition they are given from 1 to 3 mg. of stilbestrol by mouth daily. This dosage is reduced if nausea and vomiting occur. Roentgen irradiations

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to the pituitary regions are then started and are given in a series lasting from five to seven days each; each day 200 R in air are administered. The course is repeated in from two to three months if the exophthalmos has not diminished.

If the patient is thyrotoxic he is given potassium iodide, 15 gtts. three times a day, increasing doses depending on tolerance and basal metabolic readings. He is also given stilbestrol and irradiations as previously described. Recently Dr. Edward Rose has been giving our patients thiouracil, 1 to 2 gm. daily if they are thyrotoxic. Also, he has tried x-ray to the thyroid if the thiouracil is not efficacious or cannot be tolerated.

The treatment is usually of long duration and may have to be continued throughout the patient's life. The results are encouraging if not altogether satisfactory. If the patient has not had a thyroidectomy, the prognosis is much more favorable. One of the worst cases in the beginning however, made an excellent recovery (case 5).

SUMMARY

The earliest eye sign in the thyrotoxic type of Graves' disease is lid retraction. The cause of the lid retraction is unknown. It gives rise to the other lid signs in Graves' disease, such as lidlag and infrequent winking, and is the cause of the characteristic facial expression of thyrotoxicosis. Lid retraction causes a slight degree of exophthalmos, i.e., up to 3 mm. of protrusion, but produces the effect of that of a much greater degree. It is not pathognomonic of Graves' disease. Several cases are reported which are due to other conditions.

Exophthalmos can be diagnosed only by actual measurements, and even then one can only assert that the degree of protrusion of the globe is pathologic when (1) the condition is unilateral and the difference between the two eyes exceeds 1.5 mm. and (2) previous measurements have shown that an increase has occurred when it is bilateral.

Two types of exophthalmos occur in Graves' disease. One type is due to the same mechanism which causes the lid retraction, hence is of slight degree, occurs in the cases which are thyrotoxic, and disappears when the lid retraction disappears. No pathology is found in the orbit to account for this type. The other type is due to edema of the orbit, followed by cellular infiltration. It is progressive, especially in hypothyroid individuals, remains or gets worse even though the thyrotoxicosis is cured, and persists after death.

The signs by which this type of ophthalmopathic Graves' disease can be recognized are outlined as follows:

1. Edema of the lids, noninflammatory.
2. Edema of the bulbar conjunctiva, settling to the lower cul-de-sac, but not involving the palpebral conjunctiva.
3. Progressive exophthalmos.
4. Early limitation of movement of one or both globes, due to proptosis. There is little diplopia since limitations are usually bilateral and in the same direction.
5. Exophthalmos out of all proportions to signs of thyrotoxicosis; in fact, strikingly in the inverse proportion; hence, most frequently seen in post-thyroidectomy cases.

Ten case reports are presented, and the medical treatment outlined.

CASE REPORTS

Case 1.—Lid Retraction Due to Spasm of Levator Palpebrae: R. C., a 61 year old colored male, came to the Ophthalmology Clinic of the University of Pennsylvania Hospital on January 24, 1938, with the complaint of poor vision. His visual acuity was 6/60 in each eye unimproved with glasses. External examination revealed a marked retraction of his right upper lid to 4 mm. above the upper limbus. Both eyes could be closed normally. The lid retraction, which was quite apparent when the patient looked straight ahead, increased markedly on looking down. The right eye was deviated upwards 15 degrees and slightly inwards. No history of diplopia was elicited. The diplopia fields and fields of rotation indicated a weakness of the left inferior oblique muscle.

The fundi were essentially normal except for immature cataracts. Visual fields were full. X-ray of the skull showed calcification of the internal carotid arteries. Neurological consultants found no demonstrable cause for the lid retraction, or for

the disturbance of ocular motility. No change in his condition was noticed for two years.

In 1940 he came to the clinic with an exposure keratitis of the right eye, involving the lower half of the cornea. We felt it imperative to determine whether his lid retraction was due to sympathetic stimulation or to levator spasm. Accordingly, a novocaine injection of the right superior cervical ganglion was done by Dr. Norman Freeman. This had no effect on the lid retraction, although the pupil on the right side became very small and there was marked vasodilation on that side of his face. If the fissure had been effectively narrowed by this procedure we had contemplated an alcohol injection of the ganglion. Instead, we did a median tarsorrhaphy, after which the cornea healed satisfactorily.

By this procedure sympathetic stimulation was ruled out as the cause of the lid retraction. Because of the evident weakness of the left inferior oblique muscle it seemed plausible to assume that the lid retraction was due to spasm of the right superior rectus, and hence also of the right levator muscle, since the right superior rectus is the yoke muscle of the left inferior oblique. I realize that there are objections to the hypothesis; for example, why is it that the retraction of the lid continues when the patient is looking down, in which position there should be no innervation to the left inferior oblique? Whatever the actual cause of the lid retraction may be, I feel that we have shown it is not due to the sympathetically innervated muscle.

Case 2.—Lid Retraction Due to Sphenoidal Ridge Meningioma: I. L., a 25 year old white male, was referred by the Endocrine Clinic to the Ophthalmology Clinic of the Hospital of the University of Pennsylvania in July, 1937, because of unilateral exophthalmos. His vision was 6/9 in each eye. External examination of the right eye at that time showed it to be apparently normal. Examination of the left eye showed a widening of the fissure due to lid retraction and a noticeable exophthalmos. The reading with a Hertel exophthalmometer was 16.5 on the right and 18 on the left with a base line of 105. The eyes were straight in the primary position, and on looking down the left upper lid lagged markedly. The lids could be closed normally. Rotations of the globes were full. Ophthalmoscopic examination showed the fundi to be normal.

Early in September the patient began to have diplopia, and diplopia fields suggested a paresis of the left superior rectus muscle. The lid retraction was now more marked, and the eye remained opened during sleep although all the facial muscles still functioned normally. There was no evident weakness of the left orbicularis muscle. The patient was admitted to the neurosurgical service of Dr. Francis Grant.

Neurological examination aside from the eye findings was essentially negative. X-ray of the skull revealed what was thought to be a sphenoidal ridge meningioma. Visual fields were normal. Because of increasing exophthalmos and diplopia it was felt that neurosurgical exploration was indicated, A left frontal craniotomy was performed by Dr. Grant on September 23, 1937, and a sphenoidal ridge meningioma was found and removed as completely as possible.

Following this the exophthalmos diminished, so that at the present time there is no measurable difference between the two eyes. The diplopia disappeared. He developed a partial optic atrophy on the left side which reduced his vision to 6/30 in that eye. The lid retraction diminished materially but some lid lag still persists.

The cause of the lid retraction is evidently an invasion of either the levator or the sympathetic nerve supply to the upper lid.

Case 3.—S. H., a 36 year old white male, was seen March 22, 1943, because of swelling of both upper lids for the past week. Vision was 6/7.5 in each eye with correction. Near points and muscle balance were normal. Examination showed a swelling of both upper lids which was noninflammatory. There was a slight chemosis of the bulbar conjunctiva but no injection of the globe. The palpebral conjuntiva was normal. Nothing was expressed from either tear duct. The tension was normal to fingers. The fissures were of normal size; there was no lid lag or any noticeable exophthalmos. The exophthalmometer reading was 24 in each eye with a base line of 108. The anterior segments were normal to slit lamp and the ocular fundi were normal. The patient was questioned regarding allergy and was advised to return for further examination.

He was not seen again until July of the same year. At that time he showed a definite lid retraction on both sides, the left being more pronounced. Both lids were edematous (fig. 4). His exophthalmometer reading was 27 millimeters at 108. The left eye showed an exposure keratist. He was referred to Dr. Edward Rose with a diagnosis of malignant exophthalmos. Dr. Rose reported that this was the syndrome of a progessive opthalmopathy. In this case, however, there was no evidence of hyperthyroidism but on the contrary there was a definite evidence of thyroid deficiency. General physical examination revealed little of importance other than the ocular findings, except that his heart rate was slow and his blood

pressure somewhat low, averaging 110 systolic and 70 diastolic. He was moderately overweight. There was no thyroid enlargement. His basal metabolic rate was —58 per cent. This was lower than that previously reported by another laboratory which was said to be —28 per cent. His blood cholesterol was normal. X-ray of his skull and pituitary fossa showed no abnormality. He was given 5 grains of proloid daily and in addition 1 Bremarin tablet daily (the latter being an estrogenic substance extracted from the urine of pregnant mares, each tablet containing 1.25 mg. of estrone sulfate).

He was referred to Dr. Pendergrass for a series of x-ray treatments to the pituitary region. The patient was kept under constant observation and repeated exophthalmometer readings showed a maximum of 29 in the right eye and 30 in the left with a base line of 108. The prominence of his eyes became such that at one time there was some question as to whether he should not have a radical decompression done. The corneas consistently stained with fluorescein and the eyes had to be bandaged on numerous occasions to protect them. The patient finally devised an ingenious device for covering his eyes at night which consisted of hard rubber screw-on bottle tops fastened in such a way that they occluded the eyes and could be tied around the head.

When last seen on April 24, 1944 he stated that he felt much better; he was still taking 5 grains of proloid but no other medication. The last x-ray treatment was given four months ago. He had two sets in all: ten in one set and nine in the other, given four months apart. His exophthalmometer reading on the last visit was 27 in the right and 28 in the left.

Case 4.—A. B., a white male, age 41, complained of swelling of the upper and lower lids (fig. 5), especially the upper lids. Visual acuity was 6/7½ in each eye without correction. There was a noninflammatory swelling of both upper lids. The conjunctivae were chemotic and injected. The lids could close fully. The pupils were normal. The extraocular movements were slightly limited in all directions. There was no lid retraction. Convergence was present but weak. The disease was diagnosed as the ophthalmopathic type of Graves' disease and the patient referred to Dr. Edward Rose for treatment.

The history he gave Dr. Rose was to the effect that he had been well until early in July 1943, when he contracted influenza and had an elevation of temperature for about two weeks. He stated that about this time he began to note weakness, palpitation of the heart, rapid heart action, tremor and loss of weight. He stated that he had lost about 30 pounds. Dr. Rose found evidence of weight loss, tremor, tachycardia, no palpable thyroid, and marked bilateral exophthalmos with edema of the lids. He believed that this patient had a fulminating hyperthyroidism with severe opthalmopathy without goitre. Accordingly the patient was admitted to the hospital and put on conservative medical treatment.

His basal metabolic rate when first seen was +26 per cent. By December 1943, this had fallen to +2 per cent. However, in February 1944, his general symptoms returned. His exophthalmos by this time measured 29 in each eye and there was definite lid retraction on both sides. When last seen on April 20, 1944 his exophthalmos measured 29, both lids showed retraction, his corneae were clear. The patient had been taking thiouracil, but had a severe pruritus so he was given iodine instead. He was also given x-ray treatments to his thyroid. His basal metabolic rate at this time was +28 per cent.

Case 5.—H. T., a 45 year old white male, was admitted to the hospital December 15, 1941, with a complaint of poor vision and exophthalmos. He stated that about 1936 he began to notice tiredness and a decrease in the amount of work he could do. In August 1940 nervousness and irritability began. These symptoms gradually increased in severity. By January 1941, he began to notice prominence of his eyes, and in March 1941, he began to notice diplopia for near objects. A subtotal thyroidectomy was done in another hospital in September 1941, following which he was completely relieved of his symptoms. About four weeks after the thyroidectomy the prominence of his eyes and his diplopia returned.

The essential findings on admission were a well nourished male with a basal metabolic rate of −1 per cent who had marked exophthalmos and reduced visual acuity to 20/400. The lids were edematous and the fissures were wide. There was some lid retraction. Diplopia was present in all positions of gaze and rotations were greatly diminished in all directions, but especially so for upward gaze. The corneae were clear and had normal sensitivity. The exophthalmometer reading was 28 and 30. The ocular fundi were normal but the veins were markedly engorged. The visual fields showed a small cecocentral scotoma in both eyes. Because of his failure of vision and the marked exophthalmos it was decided that the orbit should be decompressed. A Naffziger operation was done by Dr. Grant on December 21, 1941. The decompression could not be as extensive as was desired because of the encroachment of the paranasal sinuses, and only 2 mm. of recession of the left globe

was obtained by operation. On January 16, 1942, a modified Shugrue operation done by Dr. Fry, who decompressed the lateral wall of the right orbit. Again only 2 mm. of recession of the exophthalmos was obtained. The usual medical treatment of these cases was then carried out. He was discharged in February 1942, but continued to receive therapy.

He was again admitted on April 13, 1942. Two weeks previously he had begun to notice increasing loss of sight in the right eye and on admission visual acuity of the right eye was limited to counting fingers; the left eye was still 20/400. The right eye showed 2 diopters of papilledema and the left showed a beginning papilledema. Exophthalmometer reading was 28 in the right eye and 29 in the left. Medical therapy was continued and in addition x-ray therapy was given to the pituitary region. After some days of irradiation visual acuity had increased to 5/200 and 20/200. The exophthalmometer reading remained the same. He was discharged June 19 with advice to continue medical therapy. Since that time he has been seen on a number of occasions. On March 17, 1943 the exophthalmometer reading in the right eye was 28 and in the left eye 27. Visual acuity in the right eye was 6/20 with correction, and in the left 6/9. He was much improved subjectively and his appearance was improved. Rotations were still limited upward and to the side. The veins in both eyes were nearly normal in size. September 29, 1943 vision with correction was 6/9 in each eye. The patient had shown remarkable improvement. He had developed an internal squint on the right side possibly due to the operation of decompression of the orbit on this side. The exophthalmometer reading was 24 in the right eye and 23 in the left eye.

Case 6.—M. H., a 45 year old colored woman was admitted to the hospital on April 28, 1942, with a history of loss of weight and nervousness for the past two years. She was referred from the Endocrine Clinic. Examination showed her visual acuity to be 6/9 in the right eye and 6/15 in the left. The fissures were widened and there was edema of the lids and limited upper rotations of both eyes. The conjunctiva was slightly injected. The corneae were clear. Fundi were normal except for angiosclerosis. Fields showed a central scotoma in the left eye. Her basal metabolic rate was +22 per cent and the exophthalmometer reading was 25 in each eye with a base line of 100.

Over a four month period the exophthalmos increased 4 mm. in the left eye. Because of the rapidly increasing exophthalmos it was decided that thyroidectomy should not be done. The case was diagnosed as the ophthalmopathic type. She was put on medical treatment and given radiation to the pituitary region. Following this she began to improve rapidly and when last seen eight months later her visual fields were normal. The vision in the right eye was 6/6 and in the left 6/9 and the exophthalmometer reading was 26 in the right and 28 in the left.

Case 7.—J. E., a 51 year old white male, was admitted to the service of Dr. Francis Grant on November 7, 1942, with the complaint of protrusion of the left eye. He had first noticed difficulty in September. The trouble began with diplopia on looking up and to the left. The first eye examination was made on November 11, 1942. Visual acuity with correction was 6/5 in each eye. Exophthalmometer reading of O.D. 17, O.S. 25. The patient had widened fissures and exophthalmos on the left side. There was some swelling of the upper lid of the left eye and the left globe was pushed slightly forward and slightly downward (fig. 6). The conjunctiva was injected and slightly edematous. The cornea was clear and sensitive. Both fundi were normal.

The patient was thought to have an orbital tumor and on November 18, 1942, Dr. Grant did a transfrontal craniotomy. No tumor was found.

The patient was readmitted to the eye ward on February 16, 1943 for further examination. Visual acuity was 6/5 in the right eye and 6/6 in the left. Exophthalmometer reading was O.D. 22, O.S. 26, with a base line of 110. The right lid at this time showed some retraction and there was beginning edema of the upper lid, and edema of the right conjunctiva. The patient had begun to complain of general nervousness, mild tachycardia, and tremor. The basal metabolic rate taken for the first time was +17 per cent. The blood cholestrol was 203. The case was then considered to be an opthalmopathic type of Graves' disease and the patient was started on potassium iodide and stilbestrol. March 11, 1943, exophthalmometer reading was 22 in the right eye and 24 in the left; the basal metabolic rate was +19 per cent. On April 19, both lids showed marked retraction, exophthalmometer reading 22 and 24, basal metabolic rate +5 per cent. His medical treatment was continued with the exception of the potassium iodide. On July 8, 1943, the exophthalmometer reading was 22 and the basal metabolic rate was +16 per cent.

Case 8.—E. H., a 33 year old white male, was admitted to the surgical service on February 6, 1941, complaining of thyrotoxic symptoms which had been present for the past four months. A diagnosis of diffuse toxic goitre was made. The basal metabolic rate was +58 per cent. No examina-

tion of the eyes is shown on the record. A subtotal thyroidectomy was done on February 19, 1941. Seven months later (September 1941) he began to notice an increasing prominence of his eyes and returned to the hospital on November 18, 1942.

The first examination made by the eye clinic was on the date just mentioned. The exophthalmometer reading in the right eye was 30, in the left 27. The extraocular movements were limited somewhat in all directions. There was slight diplopia elicited on looking down and to the left. Basal metabolic rate was +1 per cent. Blood cholesterol was 229. Visual acuity in the right eye was 6/15, in the left 6/6. The conjunctivae were injected and chemotic, the right more so than the left. He was placed on stilbestrol and thyroid therapy and given x-ray treatment to his pituitary region. A right tarsorrhaphy was done because of the prominence of the right eye and the involvement of the cornea; however, this did not hold. On January 22, 1943, his visual acuity was 6/9 in the right eye, 6/6 in the left. Exophthalmometer reading was 29 and 27. There was a small central scotoma elicited in the right eye to 1/1000 white. When last seen his condition was approximately the same. Treatment was continued.

Case 9.—L. S., a 9 year old white girl, was admitted to the hospital on August 8, 1942. She had been well until June 1942, when her mother noticed prominence of her eyes. She was first seen in the eye clinic and came into the hospital for study. Examination disclosed an exophthalmos which was more apparent than real. The reading of the exophthalmometer was 17 in the right eye and 16 in the left. There was marked widening of the palpebral fissures, retraction of the upper lids, and lid lag. Examination of the ocular fundi showed no abnormalities. The conjunctivae and the lids were edematous, especially in the right eye. Diagnosis by the medical consultant, Dr. Rose, was juvenile hyperthyroidism. By February 25, 1943, her exophthalmometer reading had increased to 20 in the right eye, and to 18 in the left. She has been on medical treatment since that date. When last seen in December 1943, exophthalmometer reading was 21 and 19. Both conjunctivae were injected and showed edema, the right more than the left. No operative procedures were contemplated.

Case 10.—M. K., this patient was admitted to the eye ward on August 7, 1939 for study. Her ocular difficulties began in 1935 at which time she had a macular choroditis in the left eye. In 1938 she had a complete ptosis of her left lid which improved under potassium iodide. The ptosis returned, however, in January 1939 and in March a ptosis of the right eye was noticed. In July a complete right abduceus paresis developed which was followed by paresis of all of her right ocular muscles with the exception of the right internal rectus. At the time of admission exophthalmos was present in the right eye.

Her exophthalmometer reading at this time was 25 in the right eye and 23 in the left. There was more edema of the conjunctiva in the left eye by September 30, 1939, but no other changes were noted. The patient was readmitted on October 16, 1939. The ophthalmometer reading was 25 in the right and 26 in the left. Her fields in the right eye were normal. Her fields in the left eye showed a central scotoma probably due to her old macular choroiditis. She had bilateral ptosis at this time and the prominence of the eyes was so great that the lids, wen closed, did not cover the lower third of the cornea. There was bilateral chemosis and infiltration of the right cornea about 1 mm. in diameter near the lower limbus which did not stain. On this admission the weakness of the right seventh nerve could not be demonstrated as had been done on her previous admission. It was thought that she might have an endocrine disorder, possibly pituitary in origin, with a thyrotoxic hormone, and a course of x-ray therapy to the pituitary region was started. Her basal metabolic rate on this admission was −12 per cent. Blood cholesterol was 240. A therapeutic test with prostigmine made on October 23, 1939 showed a definite response with immediate improvement of the movements of both eyes and lids. A diagnosis was made of an ophthalmopathic type of Graves' disease with myasthenia gravis. The exophthalmometer readings showed a gradual increase to about 28 in each eye.

Because of the exposure keratitis of the right eye she was transferred to the neurosurgical service for an orbital decompression on the right side. The orbit was found to contain a great deal of edematous muscle and fat (fig. 3), which was under increased tension. At the time of her discharge there was no significant diminution of the exophthalmos but the patient seemed to be generally improved. She was kept on medical treatment.

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REPORT OF CASES FROM ST. MARY'S HOSPITAL TUMOR CLINIC

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THE American Society for the Control of Cancer has been extremely successful, through the medium of its various branches, in impressing upon the public the mortal necessity of seeking immediate medical advice concerning any growth or other sign which might be indicative of malignant disease. Conversely, it is equally important that the doctor recognize cancer in an early stage and immediately institute appropriate treatment.

Since it has been generally conceded that cancer can be cured or at least life prolonged, if treatment is begun soon enough, it is the solemn obligation of the physician making the examination to be so thorough that cancer can be either definitely ruled out or, in case it is present its type, ascertained and a suitable method o fcure begun immediately.

The purpose of this paper is to submit a tabulation of the cases, both malignant and benign, which were registered with the St. Mary's Hospital Tumor Clinic from June 7, 1942, to January 7, 1944, with comment on their nature, the different methods of treatment and, in some instances, the results. The list, numbering 12 cases, is as follows:

MALIGNANT GROWTHS	
Bladder	6
Breast	7
Cervix	13
Intestine	13
Kidney	4
Mandible	1
Ovary	1
Prostate	10
Skin	21
Spinal cord	1
Stomach	2
Thigh	3
Uterus	5
Vagina	1
Testicle	1

PRECANCEROUS LESIONS	
Hyperkeratosis of skin	2
Leukoplakia of mouth	2

BENIGN LESIONS	
Breast	3
Cervical adenitis	2
Sebaceous cyst of head	2
Uterus	2

A large percentage of these cases were seen originally as outpatients in the Tumor Clinic. All were charity cases. The remainder were seen as hospital patients when they were registered with the Tumor Clinic by the attending physician. Not all tumor cases admitted to St. Mary's Hospital are registered, it being optional with the physician. At regular intervals, the patient is contacted either by mail or through the attending physician. Even though we have followed these cases for only a short period of time, we feel that some of them are of particular interest as regards the treatment of cancer.

Whenever possible, a biopsy is done and repeated as often as is deemed necessary. This is particularly true in cases of cancer of the cervix. No serious attempt is made to determine whether the tumor is radiosensitive or radioresistant on the basis of the biopsy. We have found that response of the tumor to treatment cannot be always correlated with what might be expected in regard to the pathological grades of malignancy. In the majority of these cases, although the patient had previously consulted a physician, no definite diagnosis had been made until a biopsy was done at the Tumor Clinic.

One woman with a large cancer of the cervix had been to six physicians, none of which apparently had made a vaginal examination. Most of the cases of carcinoma of the cervix

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(particularly the charity cases) showed on first examination, a wide involvement of the cervix and there were some with extension. In two cases, the autopsy revealed kidney complications due to involvement of the ureters either by carcinoma or by scar tissue. We would suggest a complete urological study before, during and after irradiation. It has been our experience that a competent urologist could prevent such complications as pyonephrosis and hydronephrosis. Our results in the treatment of cervical carcinoma have been poor, due, no doubt, to late diagnosis.

The malignant tumors of the skin for the most part were basal cell growths although one of the cases presented both basal and squamous cell type. In our skin cancers there were five basal cell types and nine squamous cell types. Three of the lip cancers were squamous cell type and when first seen involvement of the cervical lymph nodes was already present. There were also two malignant melanomas. Our results so far in these cases have been good, treatment consisting of deep x-ray therapy on the local growths and insertion of radon seeds in the cervical lymph glands. Early squamous cell carcinomas, especially of the limbs, have been excised in most cases with no recurrence to date. Basal cell lesions are curable in the early stage but in the late stage they are very destructive locally and are difficult to treat. Even if healing takes place, deformities usually result. In one of our cases which had its inception three years ago, there was definite deformity with necrosis of the nose when first seen at the Clinic. Basal cell carcinoma occurs especially in the face although we have seen one in the anterior axillary fold. Malignant tumors of the skin are usually treated as squamous cell lesions whether biopsy be reported as basal, squamous cell or mixed. We feel that this is the safest procedure. The treatment of two cases of malignant melanoma of the skin by wide surgical excision has proved successful. Generalized metastases developed very quickly.

In our series of intestinal carcinomas, there were seven which involved the rectum, one of which was a gelatinous adenocarcinoma. The chief complaints were bleeding and tenesmus. The majority were very large growths and, with one exception, the growth could be felt in the rectum by the examining finger. Most of these were of low grade malignancy. There was no extensive loss of weight or strength. When first seen at the hospital one case had an acute obstruction. In our series of cases, histological grading of malignant tumors of the intestine has not proved of great value as very small low grade lesions have been found associated with very extensive liver metastases and rapid termination. On the other hand, we have seen highly malignant growths with no liver metastases.

PROSTATIC CANCERS

The prostatic cancers have been treated generally by transurethral resection accompanied by bilateral orchidectomy. To date, the results have been spectacular. As yet, deep x-ray therapy for destruction of the function of the testicle has not been used.

The benign tumors of the breast were treated by simple excision. Our procedure in handling tumors of the breast includes biopsy or simple excision of the mass if it is small in size. The needle type biopsy has been used on many occasions and has been found to be satisfactory when the tissue obtained by this means was diagnosed as cancerous. On the other hand, if the tissue obtained was apparently normal, we were inclined to discount the result and remove a specimen by surgical incision.

There was one case of tuberculous mastitis in a white woman, aged 28. She presented a painless swelling of the breast of four months' duration. There was no discharging sinus nor was there involvement of the axillary region. Roentgenogram of the chest showed it to be normal and there was no family history of tuberculosis. A simple mastectomy was done.

The majority of the malignant growths of the breast were adenocarcinomas. We realize

that statistics on the results of preoperative irradiation are inadequate. We have followed the general rule of recommending preoperative and postoperative irradiation in those tumors which were obviously malignant and with axillary metastases. At the present time, in this series of cases we cannot evaluate the status of either preoperative or postoperative irradiation. Irradiation has not been given in all of our cases.

From this resume of the small series of cases seen and treated at St. Mary's Hospital, we feel that the most important factor in the treatment of cancer is the making of an early diagnosis and that by means of the Tumor Clinic larger numbers of cases can be studied.

COFFEE AND STOMACH ULCERS

Black coffee and the popular caffeine-containing carbonated beverages are bad for the one out of ten in the population who have stomach ulcers or are ulcer-susceptible.

So said Dr. J. A. Roth, Dr. A. C. Ivy, and Dr. A. J. Atkinson, of Northwestern University Medical Association.

Caffeine, they found, stimulates production of strongly acid stomach juices rich in pepsin. In normal persons this stimulation of stomach acid output is abrupt but transient. In ulcer patients and those susceptible to stomach ulcer, the effect is prolonged. The difference is so marked that caffeine can be used to help diagnose stomach ulcer and to detect ulcer susceptibility.

Excessive caffeine users, in Dr. Roth's opinion, are those who drink more than five cups of coffee a day and especially those who take coffee or caffeine-containing beverages between meals frequently. Coffee taken with cream and sugar or with meals is less harmful because the cream or other food acts as a buffer against it.—*Science Digest.*

TEAR DUCT OBSTRUCTION

A baby with history of one or both eyes watering usually is afflicted with tear duct obstruction, a defect easily removed by one or several dilatations of the duct under anesthesia. Dilatation should be postponed until the child is at least 6 months of age, for safety of anesthesia and ease of probing. These cases are to be referred to the ophthalmologist.

Weeping due to failure of the drainage system means obstruction somewhere in the tear points or lower down. If the tear points are too narrow, water cannot enter fast enough to keep from overflowing. When the lower eyelid is swollen, red and turned outward, the tear point is everted and tears cannot reach the point to be carried away. In this case, tears are made in more than normal abundance, so two factors really are causing the weeping. Infections of the tear sac will hinder passage of tears or prevent it altogether. It is generally recognized that no tear sac infection is possible unless the tear duct below is partially or completely closed . . .

No solution of eyedrops, lavage or douche can equal tears; in fact, they dilute and may hinder the efficacy of nature's own eyewash. When compresses are ordered, I specially ask that clear water be used, since it is only heat or cold that is desired. Added salts are of no value.—*Leonard F. Swihart, M.D. in J. Indiana St. Med Ass'n.*

RHEUMATIC FEVER TAKES HEAVY TOLL

Of 13,000,000 men examined under the Selective Service System over 230,000 were classified in 4-F because of cardiovascular disease. Col. Rowntree, Chief of the Medical Division, estimated that the condition in nearly one-half of those rejected was caused by rheumatic fever. A study and reexamination of 4,994 men, rejected for military service by local boards and inductions stations because of a diagnosis of cardiovascular defects or neurocirculatory asthenia, showed that the chief cause for rejections was rheumatic heart disease. This indictment for the military added to our knowledge of civilian incidence of the disease (between 200,000 and 260,000 cases per year in the U. S.) should focus greater attention on rheumatic fever. The disease is reportable in only a few states though its aftermath constitutes a major public health problem.—*R. N.*

HIGH MARRIAGE RATE FOR NURSES

A message from the Pacific front warned the girls at home to hang on to their men, for between the Australian women and the Army Nurses they're going fast. According to Lt. Col. Jane Clement, director of 3,000 Army nurses in the southwest Pacific, an average of four nurses a day are being married to fighting men in that theatre.—*N. Y. State J. of Med.*

The President's Page

Unless I am mistaken this is October, and if my reason holds aright next month will be November. Just two simple months in the calendar year 1944 but two months during which history may be made that might change the shape of our world for many years to come. It is our most profound hope and prayer that the end of the European War will be seen during these two months, and with its coming, the rapid collapse of the Japanese Empire. These, of course, are the big events that may take place, but in addition there are others, though of minor importance, but still important enough to deserve your careful thought and consideration.

Our county society meetings are beginning. I would urge your regular attendance. We have all been so busy that we may find our attendance slipping. This is bad for you, and it's bad for Organized Medicine. Large national meetings have been given up because of the war, but our local meetings will continue, so please find time to attend them. You will keep abreast of the times and your attendance will help in reorganizing the practice of medicine.

Another item on the agenda for this next month and a few days thereafter is the furor that accompanies a presidential election. I can think of no election in which the doctors should have a greater interest. As citizens of the United States we are interested in all the problems that face our country. As members of the medical profession we are vitally interested in the problems that face the future health and welfare of our people. It is for us as individuals to decide which party offers the best to Organized Medicine.

Surely you must agree that the socialization of medicine has been pushed very strongly during these past few years. As Al Smith would say, "All you've got to do is to look at the record". So I feel I'm safe in saying that the present administration is inclined to favor socialized medicine. Just how the opposition feels I have not been able to determine definitely, but I'm inclined to believe it favors free enterprise and less regimentation, and this I should interpret as meaning no socialization of medicine. These things may become more clearly defined as the campaign progresses, and if they do, then I trust that you'll let your conscience be your guide, and not some old prejudice inherited from your grandfather.

President.

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SHOCK

Twenty-five years ago Cannon stated: The theory of secondary shock which has the strongest support, both in clinical observations and in laboratory experiments, is that of a toxic factor, arising from damaged and dying tissue and operating to cause an increased permeability of the capillary walls and a consequent reduction of blood volume by escape of plasma into the lymph spaces . . . According to this theory there may be no essential difference between the effects of toxins given off by damaged tissue and of toxins resulting from activity of bacteria.[1]

According to Moon[2] the researches of the National Research Council, undertaken by diverse methods in various medical centers over a period of two years, endorse Cannon's conclusions. The prevailing opinion eliminates hemorrhage entirely as a primary causative factor. Trauma, i.e., an externally applied destructive force, is also eliminated. Simply stated the cause of shock is tissue destruction from any cause—bacterial, chemical or physical.

The toxin produced from damaged tissue causes endothetial damage to capillaries with loss of blood plasma into the tissue spaces With this there is stasis of blood in the capillaries. This results in a decrease in the amount of circulating oxygen bearing blood. The resulting anoxia can result in widespread and profound changes in vital body mechanisms (West Virginia doctors will recall the anoxia studies of Van Liere at West Virginia University as presented at a recent meeting of the State Medical Association). At the same time there is tissue dehydration and change in the electrolyte balance, especially a reversal of the sodium-potassium balance. Finally, and it has needed the crush syndrome of London bombings to emphasize it, there is the late renal destruction, clinically acute parenchymatous nephritis or nephrosis, often leading to death, supposedly from uremia—actually from shock.

This in brief is the pathologic-physological concept of secondary shock, the condition signified by most of the well informed authors when mentioning shock without qualification.

From Cannon's definition of shock it is obvious that the condition cannot at once result from burn or injury or operation. The patient in collapse (shock) admitted very soon after an injury must be suffering from something else. As mentioned in J.A.M.A.[1] such condition as this gives rise to the confusion concerning shock. We think in terms of traumatic shock, surgical shock, anesthetic shock, primary and secondary shock and by the very multiplicity of our terms become confused in our thinking. This is particularly true because the superficial clinical picture of primary shock, hemorrhage and (true) secondary shock may be the same, outside of the time factor, and the first two may subtly blend with the third. Moon[2] emphasizes the value of the hematocrit in the differentation between hemorrhage and secondary shock.

It appears that much of the confusion regarding shock can be overcome if the concept of Cannon is thoroughly understood and those phases of the presenting clinical picture inconsistent with it be thoughtfully appraised.

Therapy thereafter will be increasingly effective. It would also appear that a new series of terms to describe the hodge podge now called shock would make life easier for those of us facing its various manifestations.

1. Cannon, W. B., Medical Dept., U. S. Army in World War I. Washington. Surgeon General's Office, 1923, 11:186.

2. Moon, V. H. International Abstracts Surgery, 1944, 79:1.1.

3. J. A. M. A., April 8, 1944, Vol. 124, No. 15, Page 1060.

LOCAL MEDICAL HISTORY

The Medical Society of the State of North Carolina has taken steps to publish a medical history of the old North State. Such an undertaking is eminently proper in a state which boasts of the oldest state medical examining board, and one of the oldest of all the state medical societies. That such a publication can be successfully produced is clearly proven by the recent volume on the medical history of Kentucky, and by Dr. Wyndham Blanton's monumental three-volume "History of Medicine in Virginia."

While the history of a profession consists much more largely of individual biographies and discoveries than is the case in political and social history, there is a definite thread of continuity in medical history, and such medicoliterary undertakings covering the different states are definitely worth while and deserve the support of the profession.

Writing in the current issue of *Southern Medicine and Surgery*, that distinguished psychiatrist and medical philosopher, Jas. K. Hall, himself an expatriate Tar Heel, discusses approvingly and at some length, the proposed volume and closes with the following eloquent apostrophe to the domain of Clio, a tribute which must have warmed greatly the heart of that gentle muse:

"History, and history alone, perhaps, teaches. Were it possible for the individual to know comprehensively the history of mankind, such an individual would never be buoyed up too much by hope nor cast down too low by doubt. He would realize that life tends to be cycloidal, and what has been is that which will be. * * * He who is without knowledge of history is fundamentally ignorant; he who lacks interest in history is hopeless."

PROGRESS IN CANCER CONTROL

It is interesting to note the progress that is being made by the cancer control division of the state health department. Organized just a short time ago, the division already has under its care 64 cases of cancer, with many additional cases pending. Tumor clinics have been established in several cities and efforts are being made to provide additional clinics in areas where needed.

Recently, an experimental clinic was held in Boone county in cooperation with the members of the local medical society. Four cases of cancer were found, but seven persons who appeared for examination returned home happy in the knowledge that they did not have this dread disease.

Diagnostic clinics of this type might well be considered by groups in other parts of the state. They would be of inestimable aid to the doctors and would afford patients in rural areas an opportunity to avail themselves of the services of a competent consultant in this field of medicine.

Doctor Gerhardt is doing a fine piece of work at Charleston. He has the confidence of doctors over the state generally. The good results that will naturally follow the effective work that is now being done will serve to convince the most skeptical that it is really worth while to provide control methods for this disease with which probably 6,000 West Virginians are at the present time afflicted.

NO CANCELLATION

West Virginia doctors have always turned out in large numbers for the annual meeting of the SMA. The convention at St. Louis, November 13-16, should prove to be no exception, as it is known that doctors generally

from over the state have already made hotel reservations for the four-day meeting.

The convention will be held in the face of many difficulties, chiefly those of transportation. Some government officials felt that all sessions should be dispensed with, but many of those concerned with the conduct of the war insisted that there should be no postponement or cancellation. They felt that the good to be derived by members of the profession in knowledge gained concerning the treatment of diseases and wounds of veterans who will return to civil life after the war would considerably more than offset any advantage that might accrue to the carriers by reason of the cancellation of reservations for space.

Doctors will not be going to St. Louis for "a good time." The reverse is certainly true, as practically all entertainment features have been eliminated, including the president's reception and ball, golf tournaments and alumni and fraternity dinners.

Aside from the scientific angle, and even though doctors will be taking what is generally spoken of as a "fireman's holiday," the respite of a few days from pressing duties at home will be beneficial. The program to be presented will be of interest to doctors both in general and limited practice.

West Virginia, we feel, will be well represented at St. Louis in November.

MEETINGS CALLED FOR NOVEMBER

A meeting of the council of the West Virginia State Medical Association has been called by the chairman, Dr. R. J. Wilkinson, for November 9, at Charleston. The meeting will be held at 6 P. M., and will follow meetings of the fact finding and planning committee, the legislative committee, and the committee on medical education.

Dr. Ray M. Bobbitt of Huntington is chairman of the fact finding and planning committee. Dr. R. O. Rogers, of Bluefield, heads the legislative committee, and Dr. R. J. Wilkinson the committee on medical education.

Matters of considerable interest to the profession will be considered at the afternoon meetings of the committees, and reports will be made to the council that evening.

General News

CASE FINDING CLINICS SUPPLEMENT WORK OF ESTABLISHED TUMOR CLINICS

An experiment new in the field of cancer control was tried out successfully August 31 in Boone County, West Virginia. In cooperation with the members of the local medical society, Dr. Paul R. Gerhardt, director of the division of cancer control, and Dr. J. Ross Hunter, of Charleston, chairman of the State Medical Association's cancer committee, conducted case finding clinics at Madison and Whitesville.

Arrangements for the clinics were made by Dr. R. L. Hunter, Boone county health officer, and nursing service was provided by the public health service and the Boone-Raleigh Clinic. Eleven patients we examined and a diagnosis of cancer was made in four cases. Clinics will again be conducted in Boone county sometime in November.

In contrast with an experimental clinic of this type, tumor clinics have been established in the following West Virginia cities: Laird Memorial Hospital, Montgomery; Mountain State Memorial Hospital, Charleston; St. Mary's Hospital, Huntington; Bluefield Sanitarium, Bluefield; and St. Mary's Hospital, Clarksburg.

The division of cancer control is investigating the possibility of the establishment of other tumor clinics. It is desirable to locate them where radiological, pathological, and surgical facilities are available for the treatment of patients.

A tumor diagnostic clinic is in the process of organization at Morgantown, under the sponsorship of the Monongalia County Medical Society, and the establishment of clinics at Parkersburg and Fairmont is being seriously considered by committees of local medical societies in those cities.

As of September 15, 64 active cases of cancer were under the care of the division of cancer control. Provision has been made for handling additional referrals without delay. Applications for care through this new division are now filed with the local departments of public assistance, but it has been made clear by Doctor Gerhardt that an individual need not be receiving aid from the department of public assistance to be eligible for such care. Under the provisions of the cancer control

law passed at the 1943 session of the legislature, the DPA furnishes information concerning the financial circumstances of the applicant and the division determines whether or not aid should be extended. The possibility of developing additional channels through which applications may be made is now being given consideration with a view to speeding up the work of the division.

1945 COMMITTEE ON ARRANGEMENTS

Dr. H. V. Thomas, president of the Harrison County Medical Society, has appointed a local committee on arrangements in connection with the 78th annual meeting of The State Medical Association at Clarksburg May, 4-5, 1945. The committee is composed of Dr. C. O. Post, chairman, and Drs. J. E. Wilson and Frank V. Langfitt.

Room reservations for the meeting are being accepted by the convention hotels, the Waldo, Stonewall Jackson, and Gore. The committee feels that a sufficient number of rooms will be available to take care of all guests, but it is important that reservations be made just as soon as possible so that the hotels may have some idea just how many rooms will be necessary to provide adequate accommodations for the members of the Association.

EMIC IN WEST VIRGINIA

A total of 7,094 cases have been approved in the Emergency Maternal and Infant Care program in West Virginia from the date the program started (May 12, 1943), to September 1, 1944. Of this number, 3,514 cases had been completed. Figures compiled on that date show that 710 doctors, 64 hospitals, 31 osteopaths, and five midwives were participating in the program.

A total of $534,850 has been authorized, and $316,371 already spent on cases in this state.

Dr. N. G. Angstadt, director of the bureau of county health work, has been acting director of the division of maternal and child hygiene since the resignation of Dr. Lenore P. Chipman in June.

INDUSTRIAL NURSES' INSTITUTE

Industrial Nurses' Institutes will be held at Fairmont October 17, and at Wheeling October 19.

The institutes have been planned by the Tri-County Industrial Nurses' Club and the Ohio Valley Industrial Club, and will be conducted by Miss Ruth Kahl and Elna I. Perkins, of the USPHS, and Miss M. E. Ingoldsby, of the State Health Department.

ADVISORY COMMITTEE APPOINTED FOR PHYSICAL RESTORATION SECTION

The appointment of a professional advisory committee to the physical restoration section of The West Virginia Board of Vocational Education has been announced by Dr. Robert J. Reed, president of The State Medical Association.

The committee is composed of Dr. Thomas H. Blake of St. Albans, and Drs. Hugh A. Bailey and Thomas G. Reed of Charleston. The appointment was requested by F. Ray Power, director of the new division, "because of their outstanding contribution in a similar advisory capacity to the adult physical restoration program of the department of public assistance."

The physical restoration program of the division of vocational rehabilitation includes provisions for surgical, medical, and psychiatric care, hospitalization, physical therapy, occupational therapy, and artificial appliances for clients who meet the criteria for eligibility for the services of the division and who are medically indigent.

According to Mr. Power, the duties and responsibilities of the professional advisory committee will include meeting from time to time to advise the division of rehabilitation and the supervisor of physical restoration with respect to general policies, setting of standards, selection of rates and methods of payment for services, supplies and prosthetic appliances, methods of medical reporting and record keeping of case workers, and assisting in interpreting to the professional personnel and institutions participating in the program the policies and procedures adopted by the state board of vocational education.

Dr. Norman G. Angstadt, director of the state health department's bureau of county health work, has been appointed as part-time medical (administrative) consultant. His duties include day-to-day consultation with the supervisor of physical restoration in individual cases and specific medical problems, advice with regard to the execution of the policies for physical restoration; assistance to the supervisor in representing the state agency in its contacts with the medical and associated professions; assistance in the maintenance of the standards established by the state agency for the selection of physicians, hospitals and other medical personnel and facilities qualified to serve various types of cases and for payment to physicians, hospitals and others; and

assistance in training the rehabilitation casework staff with reference to physical restoration.

The physical restoration program is already functioning with medically indigent clients being provided with such prosthetic appliances, surgical correction and therapeutic treatment as is necessary to restore them to physical fitness for jobs in industry, which is the objective of all physical restoration in the new division.

$30,000,000 FOR POLIO FIGHT

According to Basil O'Connor, president of The National Foundation for Infantile Paralysis, the American people in the last eleven years have contributed $29,562,742.54 to conquer infantile paralysis. This money was raised through the celebration of President Roosevelt's birthday and the March of Dimes, held in January of each year, beginning in 1934. More than half of the total (sixteen million dollars) was raised in the two years of 1943 and 1944.

Speaking at the opening of the annual meeting of the medical society committee of The National Foundation, held in New York City, September 11, Mr. O'Connor said that some idea of the scope and extent of the program of scientific research when it is realized that, since its organization six years ago, it has made 298 grants to 74 institutions involving 114 groups of workers in one of the world's greatest scientific attacks against any disease.

During the past eleven years, contributions totaling almost $15,000,000 have been left with the counties where raised to provide the best in medical care for the thousands of new patients reported each year. Of the remainder of the total, The National Foundation has received approximately 13 million dollars.

STATE NURSES TO MEET

The annual meeting of the West Virginia State Nurses' Association will be held at the Windsor Hotel, Wheeling, October 26-28. Addresses will be delivered by several nationally known men and women prominent in the fields of medicine, nursing and public health work.

One of the speakers on the program, Dr. J. W. Crosson, formerly resided at Charleston, where he served as director of the division of maternal and child hygiene in the state health department. At present he is assistant medical director of the research department of Sharpe & Dohme.

ACS CANCELS CLINICAL CONGRESS

The annual clinical congress of the American College of Surgeons, scheduled for October 24-27, at Chicago, has been cancelled by The Board of Regents "because of the acute war situation." In making the announcement, Dr. Irvin Abell, of Louisville, Chairman of the Board, said that the action was taken after consultation with the officials in Washington.

At the annual meeting of the Board of Regents which will be held later in the year fellowship in the College will be conferred *in absentia* on the class of initiates of 1944, as there will be no convocation exercises. At the same time the list of hospitals, cancer clinics, medical services in industry, hospitals conducting programs of graduate training in surgery, and medical motion pictures, that meet the College standards, will be approved and later published.

All present officers, regents, governors, and standing committees will continue in office.

RELOCATIONS

Dr. T. H. Millman, of Earling, secretary of the Logan County Medical Society, has moved to Richwood. Dr. C. Leonard Brown, of Holden, has been elected secretary to succeed Dr. Millman.

Dr. I. O. Wilson, of Van, has moved to Highcoal, and Dr. E. D. Jackson, of Killarney, has taken over the industrial practice at Van.

Dr. John H. Hodges, formerly of Martinsburg, is now a member of the teaching staff at Jefferson Medical College, Philadelphia.

Dr. S. W. Jabaut has moved from South Charleston to Shinnston, where he is attached to the medical unit of the Consolidation Coal Company.

Dr. J. Carney Hardman, of Huntington, has accepted a position on the medical staff at the Consolidation Vultee Aircraft Corporation plant at Fort Worth, Texas.

Dr. Eugene S. Carter, secretary of the Fayette County Medical Society, has moved from Boomer to Minden.

Dr. Frank M. Huff, who has been on the staff at St. Luke's Hospital, Bluefield, for the past several years, has moved to Oklahoma City, Oklahoma.

Dr. R. L. Waddell, of Shinnston, has moved to Sparta, North Carolina.

Dr. Ralph Frazier, of Gary, has assumed charge of the former industrial practice of Dr. T. B. Daugherty at Fayetteville and Kaymoor. Dr. Daugherty recently to Richmond, Va.

SMA AT ST. LOUIS

The annual meeting of The Southern Medical Association at St. Louis November 13-16, will as usual, draw heavily from the profession in this state. At the Richmond meeting in November 1942, 55 doctors were registered from West Virginia, and 102 made the trip to Cincinnati last fall.

The program arranged is one of the best in the history of the Association. Three clinical sessions will be presented concurrently by St. Louis members of the profession Monday afternoon November 13. These sessions will continue until Tuesday noon, and will be followed by the programs of the twenty sections of the Association, which will last through Thursday, November 16.

All meetings will be held and exhibits set up at the Municipal Auditorium, and activities will include programs by the following organizations meeting conjointly with the Association: American College of Chest Physicians, Southern Chapter; American Society of Tropical Medicine; American Public Health Association, Southern Branch; and National Malaria Society.

Public programs will be presented Tuesday and Wednesday evenings in the Gold Room at the Hotel Jefferson. Addresses by Dr. James A. Ryan of Covington, Kentucky, president of the Southern Medical Association, and Dr. Herman L. Kreschmer of Chicago, President of The American Medical Association will feature the first public session. "Medicine in the War" will be the theme of the meeting on Wednesday evening at which top ranking officers of the Army and Navy will appear as speakers.

WEST VIRGINIA DOCTORS ON PROGRAM

Two West Virginia doctors have a prominent place on the program at the Ninth National Assembly of the U. S. Chapter of the International College of Surgeons, at the Benjamin Franklin Hotel, Philadelphia, Oct. 3-5.

Dr. Benjamin I. Golden, of Elkins, who is treasurer of the chapter, will preside at the scentific assembly October 3, and will present a paper October 5 on the subject of "Massive Single Doses of the Sulpha Drugs." Dr. John E. Cannaday, of Charleston, will present a paper at the morning session October 4. His subject is "The Cutis (Derma) Graft Transplant." Motion pictures and slides will be shown in connection with this address.

NORTHERN DISTRICT HEALTH CONFERENCE

The annual Northern District Health Conference will be held at the West Virginia Training Center at Morgantown October 16. Dr. J. A. Dolce, of Fairmont, director of the Marion county health department, will deliver the principal address at the morning session. He will speak on "Public Health in the Schools."

Following the section meetings in the afternoon, the new training center will be formally dedicated. Dr. J. E. Offner, state health commissioner, will preside and short addresses will be delivered by Dr. W. K. Sharp, director district 2, and Dr. Vane Hoge, head of hospital facilities, state relation division, U. S. Public Health Service.

SYMPOSIUM ON CANCER

Dr. Paul R. Gerhardt, director of the division of cancer control, has been selected as one of the discussants at the symposium on cancer to be held in connection with the war conference of the American Public Health Association at New York, October 2-5. At the evening session on October 2, he will discuss papers presented by J. Louis Neff, Executive Director of the American Cancer Society; Dr. R. R. Spencer, head of the National Cancer Institute at Bethesda, Maryland; and Dr. Louis C. Kress, director of the division of cancer control of the New York State Health Department.

The papers to be presented will stress the role of nonofficial agencies, the federal government, and the state health departments in cancer control.

PHC MEETS OCT. 2-4

At least twenty-five applicants for licensure by examination and reciprocity will appear before the Public Health Council at the regular fall meeting at the Daniel Boone Hotel, Charleston, October 2-4.

HEALTH OFFICER TRANSFERRED

Dr. Ward Oliver, of Pt. Pleasant, health officer for district 3, was transferred to Morgantown September 17, where he will succeed Dr. W. B. Bailey, as Monongalia county health officer. Doctor Bailey was transferred to Norfolk, Virginia, effectice October 1. Doctor Oliver's successor has not yet been named.

BUY MORE WAR BONDS AND STAMPS.

WITH DOCTORS IN THE SERVICE

Capt. John P. Brick who has been in the Canal Zone for nearly three years, is now assigned to the Redistribution Station of the Army Ground and Service Forces at Miami, Florida. He reports that Major J. C. Ford, of Huntington, who has also been in the Canal Zone for several months, is in the same outfit with him at Miami Beach.

* * * *

Major Athey R. Lutz of Parkersburg is chief of the orthopedic service at a general hospital in England. "We are receiving all of our patients by air," he writes, "and, therefore, getting the most urgent and serious cases. This hospital is a busy place right now, and I can finally understand why I have been in England for nearly two years.

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Major J. E. Dunman, of Gary, is assigned to the 165th General Hospital at Camp Grant, Illinois.

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Capt. W. L. Cooke, of Charleston, is with an evacuation hospital on an island near New Guinea.

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Lieut. Louis H. Nefflen, of Parkersburg, who has been stationed at Camp Campbell, Kentucky, is now assigned to the P.O.W. camp at Trinidad, Colorado.

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Capt. George Lyon (MC) USNR, who has been stationed in England for the past two years, is now on leave at his home in Huntington.

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Lieut. William A. Bevacqua (MC), USNR, of Parkersburg, is with the medical unit of a construction detachment in the coast guard, operating in the Southwest Pacific.

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Dr. Roger E. Clapham, of Martinsburg, has been commissioned a lieutenant commander in the Navy and is attached to the Naval Advance Depot at Portsmouth, Virginia. Lieut. (jg) J. A. Rusmisell, Jr. (MC), USNR, of Buckhannon, is assigned to the U. S. Naval Hospital in that city.

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Lieut. Comdr. W. R. Daniels, of Huntington, is attached to the V-12 Naval Unit at Dennison University, Granville, Ohio.

Major John W. Whitlock, of Amigo, is attached to the 312th Medical Battalion at Fort Jackson, South Carolina.

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The Veteran's Administration has announced the appointment of two West Virginia doctors to full-time positions. Dr. Harry A. Giltner, of Parkersburg, will have headquarters in Washington, D. C., and Dr. Herbert B. Wise, of Kingwood, will be stationed at the Veteran's Hospital in Huntington.

These three West Virginia doctors in the naval service are assigned to the headquarters squadron of the same Marine Air Group on an island in the Southwest Pacific. They are (l. to r.) Lt. A. J. Villani, of Welch; Lt. Comdr. B. H. Pollock, of Southside; and, Lt. Comdr. C. A. Smith, of Beckley.

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Capt. Edward Press, of Charleston, formerly assistant director of the division of maternal and child hygiene of the state health department, is assigned to the station hospital at the Army Air Field at Homestead, Florida. He writes that the hospital and medical service provided is of the very best.

"I even do some pediatrics on occasion," he says. He reports great groves of mosquitoes and sand flies, with scorpions and land crabs always around the camp, but says that they are blessed with nearly all the comforts of civilian life.

Captain Press successfully passed the American Board of Pediatrics late in 1943.

Commander J. D. Bird, Jr., of Wheeling, is assigned to the U. S. Naval Hospital at Norman, Oklahoma.

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Capt. Vincent Prioletti, of Holidays Cove, is with the station hospital at Camp Van Dorn, Mississippi.

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Capt. J. E. Mangus, of Pineville, is on the staff of the Stark General Hospital at Charleston, South Carolina.

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Lt. Col. Bert Bradford, Jr., M.C., with the invasion forces in France.

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Captain A. B. Carr, of War, has been assigned to the regional hospital and physical examining board at Fort Knox, Kentucky, for the past two years, and has served as president of the board since early in 1943. He has one son in the service (A. S. T. U.) at the Medical College of Virginia.

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We asked Lieut. (jg) John T. Jarrett of Dunbar, who is on the surgical staff of a carrier operating in the Pacific, to write to us concerning life on shipboard, but he reports that censorship restrictions are such that he is unable to do so at the present time. He states that much of the story is told in "Carrier Action," which appeared in the July 17 issue of Life.

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Lieut. Comdr. A. L. Osterman, of Wheeling, is assigned to the Marine Barracks, U. S. Naval Hospital, at Quantico, Virginia.

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Dr. Otis G. King, of Bluefield, who is assigned to the Woodrow Wilson General Hospital at Staunton, Virginia, has been promoted from first lieutenant to captain.

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Dr. Louis E. Baron, of Mannington, who is medical inspector at the Mason General Hospital, Brentwood, Long Island, has been promoted to the rank of major.

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Lieutenant L. R. Leeson, of Parkersburg, is assigned to Letterman General Hospital at San Francisco.

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Lieut. E. J. Humphrey (MC), USNR, of Huntington, has been transferred from the U. S. Naval Hospital at Bainbridge, Maryland, to the U. S. Naval training station at Newport, Rhode Island, and writes that he is the only West Virginia doctor there at this time. Commander R. S. Widmeyer, of Parkersburg, was detached there in July, and is now located at the U. S. Naval Air Station Dispensary at Sanford, Florida.

Lieutenant Humphrey was attached to the surgical department of the hospital at Bainbridge for several months, and is now in pre-commissioning training of a crew for a new ship that is to be commissioned early in October. He will be assigned to the ship as medical officer. "I had lots of gynecological surgery while at Bainbridge," he writes, "but of course none here, and no prospects of any from now on. We should get a lot of casualty work on the type of ship on which I will be stationed."

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Commander Berlin B. Nicholson (MC), USNR, of Parkersburg, who has been stationed at Camp Perry, Williamsburg, Virginia, is now attached to Corps Evacuation Hospital No. 2 at Camp LeJeune, North Carolina.

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A son was born August 26, to Lieut. Commander and Mrs. John Edwin Lutz, of Charleston. He has been named John Edwin Lutz, Jr. His

mother is at present residing at Gallipolis, Ohio, and Commander Lutz is on sea duty in the Southwest Pacific.

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Lieut. Comdr. E. V. Jordan, of Charleston, has been transferred from Camp Wallace, Texas, to the APA Pre-Commissioning school at Seattle, Washington.

Several West Virginia doctors are with the famous Fourth Division in France, which has been accomplishing so much in the drive toward Germany. The division has been commended for the splendid work that has been done in the treatment and evacuation of casualties.

The following West Virginia doctors are known to be with this division: Major K. M. McPherson, of Beckley (awarded the Bronze Star for action on D-day); Capt. George L. Armbrecht, of Wheeling; Capt. Donald L. Butterfield, of Milburn; Capt. Lucien M. Strawn, of Morgantown; Capt. L. H. Layman, of Holden; and Capt. Eugene R. McNinch, of Weirton.

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Major Fred E. Brammer, of Dehue, is now stationed in British Guiana, South America, and is commanding officer of a station hospital.

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Captain Herbert Shanes of Coalwood, who has been in Corsica with a fighter group, is now with the invasion forces in France.

A CHRISTMAS TIP

Next to the Bible, reports a Marine combat correspondent overseas, the most popular items of reading matter are those contained in almanacs such as offered for sale by metropolitan newspapers. The correspondent, writing to the U. S. Marine Corps at Washington, strongly recommends these almanacs as Christmas gifts for men abroad.

"The reason is simple," he explained. "The most favored form of recreation is arguing about anything and we have learned that for settling such arguments and for deciding winners of bets there's nothing better than an almanac.

"The first day my copy arrived, it was used to settle bets on the capitals of Massachusetts, Tennessee and West Virginia; the relative populations of Texas and New York City; the population of Japan, and the date of the first Louis-Schmeling fight."

Obituaries

BENJAMIN F. MATHENY, M.D.

Dr. Benjamin F. Matheny, member of the staff of the Tucker County Hospital, at Parsons for several months, died of a coronary occlusion September 8, 1944.

Doctor Matheny was born at Cornell, Illinois, son of Enoch R. and Elmina Stoneking Matheny. He graduated from Baltimore University School of Medicine in 1905. He was a member of the Barbour-Randolph-Tucker County Medical Society, the West Virginia State Medical Association, and the American Medical Association. He was a Fellow of the American College of Surgeons, and the American Psychiatric Society.

Doctor Matheny located at Clarksburg in 1906 and resided in that city until 1943, serving as coroner of Harrison county for several years. He was for years a members of the Harrison County Medical Society.

Besides his widow, Marie Elizabeth (Shinn) Matheny, he is survived by two sons, two daughters, and a brother, Floyd Matheny, of Clarksburg.

WILLIAM S. STEELE, M.D.

Dr. William S. Steele, 77, who had practiced in the coal fields of Mercer and McDowell counties for the past fifty years died at his home in Grantwood Park, at Princeton, August 27, after a long illness. He graduated in medicine at the Baltimore University School of of Medicine in 1893, and was licensed to practice medicine in West Virginia the same year. Besides his widow, he is surveved by several children, two sisters, and a brother, Dr. M. L. Steele of Valley Head, Virginia.

AIR CORPS TRAINS 200,000 IN 1943

In the 19 years prior to Pearl Harbor the Army Air Forces trained less than 7,000 pilots; in 1943 more than 207,000 received instruction in colleges and flight training centers.—*Science Digest.*

AUXILIARY EXECUTIVE BOARD TO MEET

The regular fall meeting of the executive board of the Woman's Auxiliary to the West Virginia State Medical Association will be held at Charleston, Tuesday morning, October 3, at ten o'clock, at which matters concerning the work of the auxiliary for 1944-45 will be discussed.

County Society News

FAYETTE

A dinner meeting of the Fayette County Medical Society was held at Montgomery, September 19. The guest speakers, Dr. J. Ross Hunter, of Charleston, and Dr. Paul R. Gerhardt, director of the division of cancer control of the state health department, discussed the treatment and control of cancer. After the dinner, the meeting was transferred to the "Little Theatre" of the West Virginia Institute of Technology, in that city, where Drs. Hunter and Gerhardt addressed a large crowd in open meeting. A cancer control film was shown during the evening.

CLAUDE F. FRAZIER, *M.D.*, *President.*

KANAWHA

Dr. Louis H. Douglas, Professor of Obstetrics at the University of Maryland, was the guest speaker at the regular monthly meeting of Kanawha Medical Society, held at the Daniel Boone Hotel, Charleston, September 12. He presented an interesting and informative paper on "Caesarian Sections" which was discussed by Drs. W. E. Hoffman, W. W. Point, Henry Baum, and others. An instructive paper was presented at the same meeting by Dr. G. G. Irwin. He spoke on "Ruptured Urethra Associated with Fractured Pelvis." This paper was discussed by Dr. Walter Putschar.

Dr. L. P. Stanley, formerly of New Martinsville, was approved as a transfer member from the Wetzel County Medical Society.

A committee composed of Drs. Henry Baum, A. P. Hudgins, and F. A. Clark, was appointed by Dr. W. C. Stewart, president, for the purpose of considering the idea and studying the methods of operation of monthly discussions of all newborn infant asd maternal deaths in the Charleston area. This commitee is to present its recommendations at the October meeting.

WM. P. ELKIN, M.D., *Secretary.*

LOGAN

Dr. R. K. Stevens, of Huntington, delivered a paper on the subject of Arthritis at the regular monthly meeting of the Logan County Medical Society, held at the Aracoma Hotel, Logan, Wednesday evening, September 13.

C. LEONARD BROWN, M.D., *Secretary.*

Book Reviews

SIMPLIFIED DIABETIC MANAGEMENT—Josept T. Beardwood, Jr., MD., F.A.C.P., and Herbert T. Kelly, M.D., F.A.C.P:, Assistaant Professor of Medicine, and Associate in Medicine, respectively, Graduate School of Medicine, University of Pennsylvania, Philadelphia. Philadelphia: J. B. Lippincott Company. 168 pp. $1.50.

This fourth edition of "Simplified Diabetic Management," written for the physician as well as for the lay public afflicted with diabetes, suggests itself for wide use in the treatment of the intelligent patient.

The initial chapters give a description and interpretation of the disorder and outline the various approaches to its control, its important signs, symptoms and dangers; in fact, they constitute a comprehensive compendium for the layman as to what to do and what not to do,

A good part of the book is taken up by very complete and valuable tables of the various foods in the raw and in a prepared condition, giving their contents of CHO, fats and proteins per hundred grams of edible parts.

As an important addition and a new method in books on diabetes, the authors have introduced a "unit" system which is helpful in the composition of diets more colorful than the routine diabetic meals. Three "units" have been established: Unit A is the quantity of the respective foodstuffs representing just five grams of CHO and one gram of protein; unit B represents five grams of protein and ten grams of fat; unit C represents A plus B, that is five grams of CHO, six grams of protein and ten grams of fat.

For these units, all measurements are given threefold: In the metric system, by avoirdupois, and in household measures. The latter seem particularly important since it can be assumed that the average diabetic patient, or the person taking care of him, will prefer those to actual weighing which is strongly recommended and for which a practical scale is demonstrated.

By eliminating one basic step in the computation of meals, this system of units greatly simplifies the making up of diets.

It is obvious that only the intelligent and cooperative patient will really benefit by the use of this new system. This also holds true for the physician. However, a diabetic requires understanding of his disorder if he is to enjoy his life within safe and reasonable limits of culinary variety.

'—R. J. KENT, M.D.

WEST VIRGINIA FOLKMEDICINE

Those who were born prior to or during the Gay Nineties are old enough to remember when almost every boy and some men carried buckeyes in their pockets to ward off rheumatism. Many boys and girls were sent to school with a bag of asafetida tied around their necks as a protection against diseases. A special kind of mumbo jumbo was used to kill warts. To kill a hop toad meant that your cow would give bloody milk. The presence of a bird in the house meant death. Even today people whom we consider perfectly sane knock on wood when making a boast and cross their fingers to bring good luck.

Folkmedicine as practiced in Italy in the past is treated most interestingly by Walton Brooks McDaniel, Professor of Latin, Emeritus, University of Pennsylvania, in *Transactions and Studies of the College of Physicians in Philadelphia*, for June, 1944. In many ways, the magic of the past parallels the chimney corner methods used to prevent disease and effect cures not so very long ago right here in West Virginia.

The ancient Romans used to spit three times to ward off the evil eye of danger and as a protection against diseases. Who among us does not make a wish as we look at a new moon over our left shoulder? Even today we spit upon our hands to add weight to a blow. Watch any man with a sledge hammer. This is an old custom handed down from the Romans.

Where victims of fever in Italy even today are fed bugs in various numbers, seven or nine, taken in a fresh egg or bread, there are many today in this country who feel that they are courting disaster if they lay a hat on a bed or carry a two-dollar bill. If salt is spilled on the table, a pinch of it must be thrown over the left shoulder to prevent trouble, and ladders are still things not to be walked under.

The extent of medical lore or folkmedicine that was part of the lives of people living in West Virginia even during the past half century is appalling to those who have known nothing but modern medicine. In his travels over West Virginia, J. H. Hickman, of Charleston, editor of *The West Virginia School Journal*, has made quite an extensive study of the subject. Professor Carey Woofter, of Glenville State Teachers' College, has also been interested, and they have, as a hobby over the years, gathered together threads of West Virginia folkmedicine handed down from generation to generation even to the present day. It is quite interesting to note the similarity of treatment administered by our forebears to the magic or charm medicine used by the ancient Romans, as reported by Professor McDaniel.

The following is a digest of remedies for some of the more common diseases in the late nineties and the early part of the 20th century:

Warts

Application of the blood that clings, or adheres, to a teather (stem) when plucked from a black hen will cause warts to go away.

To take off a wart rub it where the hogs scratch.

If you have a wart rub it with a piece of silver and the wart will disappear.

If you will gather gravels and rub each wart with a gravel, then tie the gravels up in nice packages and lay them in the road, your warts will leave you when some one picks up the packages.

Rub a wart with a grain of corn until the wart bleeds, burn the grain of corn, and the wart will disappear.

You can remove warts by washing your hands in stump water.

Buy somebody's warts, and if they forget it, the warts will leave.

Put castor oil on warts to drive them away.

Drop the dirt from a newly dug grave on a wart and it will leave.

Rub the blood of a black rooster on a wart and it will disappear in ten days.

To wash your hands in water where eggs have been boiled will bring warts.

Snake Bite

Cut a chicken in two pieces and place them over a snake bite to draw out the poison.

Put the stone which is found in the gall of a buck on the bite of a snake or a dog and the stone will fasten itself there until it draws out all of the poison.

When a snake bites you apply snake weed to the bite.

Fried onions will cure snake bite.

Put gunpowder into a snake bite.

Crude oil and salt, mixed, will cure snake bite.

A poultice made from boiled poke root will cure any snake bite.

Rub a hazel limb over a snake bite and the poison will be drawn out.

Fevers

If you take plaintain roots boiled in sweet milk it will cure a fever.

A spider shut in a nut shell will cure a fever.

By scraping an herb root upward the temperature of a patient may be raised; by scraping it downward, lowered.

Nosebleed

Tie a wool string around the thumb to stop nosebleed.

Hold your nose over the bit of a sharp axe and the bleeding will stop.

Let nine drops of blood fall under a rock which then is placed in its former position and the nosebleed will be cured.

When your nose bleeds put a cross under it and it will stop bleeding.

Asthma

To cure asthma place an old dishcloth under the front steps. When decayed, the person for whom it was placed will be rid of asthma.

A mullein leaf buried under the drip of the house will cure asthma.

Kill a muskrat and wear the hide on the chest to cure asthma.

Cut a mullein stalk the exact height of a child who has asthma. Lay the stalk above the door. When the child is longer than the mullein stalk the asthma will be cured.

Whooping Cough

Mare's milk is good for whooping cough.

Let a stallion blow in a child's face to cure whooping cough.

To take children in the mines will cure whooping cough.

When a child has the whooping cough, place a woolly worm in a thimble and tie the thimble around the baby's neck. As the worm begins to die, the cough will begin to leave the child.

Pass a baby three times under the raspberry bush and it will never take whooping cough.

A child who has never seen its father can feed bread and butter to another child and keep it from taking whooping cough.

Colds, Sore Throat and Pneumonia

Tie a silk stocking around your neck to cure the sore throat.

To cure a child of croup rapidly pass it back and forth through a horse collar.

To cure bronchitis, puta lock of the person's hair in a hole in a tree and put a cork in the hole.

When the first snow comes, run around the house three times barefooted and you will never take cold.

Drink a quart of snake root tea for a cold.

Tea made from a pig's toenails will cure pneumonia.

Horehound tea will cure a cold.

To jump in the river will cure a cold.

To cure sore throat use yellow root tea.

Cuts, Felons and Gatherings

If you want a cut to heal quickly keep it tied with a woolen string.

Stick the knife with which you have cut yourself in the ground and the flow of blood will stop.

Bandage a cut in its own blood.

Slippery elm poultices will draw the poison out of infections.

Yellow and unsalted butter cooked together will cure running sores.

Poultice a gathering with a slice of fat pork.

Draw a gathering with pine tree rosin.

Draw a gathering with a poultice made from carpenter's square.

Draw a gathering which is obstinate with a poultice made from the root bark of a black haw bush.

Poultice a gathering with a wilted beet leaf.

To cure a felon hold your finger in boiling water for one minute.

Hiccoughs

A hot bran poultice put on the stomach will cure hiccoughs.

Three sups of water from a tea cup will cure hiccoughs.

Sneezing will cure hiccoughs.

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Toothache

Bite a dead man's toe to cure the toothache.

To cure the toothache put your feet under the drip of the house and think of a red fox.

If the brains from a fresh-killed rabbit are rubbed on a baby's gums, the teeth will come through easily.

Blow smoke in the ear to cure toothache.

Put a piece of cast skin from a snake in a hollow tooth and it will quit aching.

Summer Complaint

To cure diarrhea drink blackberry cordial.

Pour water over the bruised bark of slippery elm and let stand. Drink the solution for a cure for summer complaint.

Make a draught from the leaves of the black currant to cure summer complaint.

Rheumatism

Put a hole in a nutmeg, put it on a string and wear it around your neck to cure rheumatism.

To cure aches in the bones drink a pint of white balsam tea each night before going to bed.

Fill a quart bottle with fishing worms and set in the sun until the oil is rendered out. This oil will cure the rheumatism.

To carry a potato in your pocket until it is petrified will cure the rheumatism.

Tying a copper wire around the leg will cure the rheumatism.

Goiter

If you have goiter on your neck and find a bone, rub the goiter nine times with the bone, lay the bone down where you found it, and the goiter will go away.

Wear live toads around your neck to cure goiter.

Wear a string cut from the clothing of a dead relative. When the string rots the goiter will disappear.

Wear a string of Job's tears around your neck and you will never have goiter.

Freckles

To remove freckles, wash the face with the first water drawn by a new-born child.

To remove freckles, wash your face nine mornings with dew.

The first showers in May will remove freckles.

Pick the first ripe strawberry. Eat half of it and rub the other half over your face. Freckles will disappear.

Thrush

To cure thrush, take nine cellar bugs, sew them up in a bag, and tie them around the child's neck. Leave them nine days. When they turn to a powder, the thrush will be cured.

To cure thrush, pour water in a stranger's shoe and let the child drink from it.

If you tie nine sage leaves around a baby's neck it will cure thrush.

Diphtheria

Dilute nitrate of silver until it will make a chicken feather curl at the tip, swab out the throat of a child that has the diphtheria with it, and the child will be cured.

To cure diphtheria, gargle the throat with a mixture of pokeberry root tea and tincture of iron.

Miscellaneous

Eczema can be cured by wearing a live frog tied to one's leg and left there until the frog dies.

Poultices made of red pepper will cure skin diseases.

To cure boils, put bullets in cow's milk, boil the milk, drink it and the boils will leave.

If there is a kernel under the jaw, rub your index finger in pot black, draw a circle around the kernel, and it will disappear.

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Whoever goes into the room of a person afflicted with a cancerous sore will be taken with a twitching of the knee.

To cure the yellow jaundice rub your breast against the galled places on the shoulders of a dun horse.

Put three chips of wood in a pan of water and place them under the bed to stop night sweats.

To get a fish bone out of your throat pull your big toe.

Rub a sty with a wedding ring and it will be cured.

Draw a live fish nine times through the mouth of a child and it will quit slobbering.

To cure mumps rub the swollen parts over the smooth places in the hog trough.

To put a tea cup on your head will cure headache.

To cure deafness, scrape a radish, salt the scrapings, and put a few drops of the juice in the ear each night between full moons.

Make a woman who is in labor sniff snuff to cause quicker birth.

PULSE STOREHOUSE OF INFORMATION

Even before physicians devoted their attention to inspecting the heart, the pulse was regarded by the physician as an inexhaustible storehouse of information. It still remains so. The physicians of ancient Egypt two thousand years before the birth of Christ felt the pulse of their patients. Rufus of Ephesus, who practiced during the reign of Trajan in the second century, wrote a treatise on the pulse, of which Sir William Broadbent in 1890 remarked, "His description of the different characters of the pulse leaves little to be added at the present day." Sir James Mackenzie, who contributed most to our knowledge of heart conditions in his generation by the use of the sphygmograph and instrumental methods, wrote the following as late as 1926, "In the examination of the arterial pulse several methods may be employed, as exploration by the finger, by graphic records, and by instrumental measurements of the arterial pressure. By far the most important of these methods is the first. There is a tendency to exalt the others at the expense of the digital, but no apparatus can ever replace the trained finger. No doubt the other methods can give very definite information of a limited kind, but in diagnosing the patient's condition they should only supplement the digital examination."—*Ralph H. Major in New Orleans Med. and Surg. J.*

S. M. A. AUXILIARY MEETING CANCELED

The annual meeting of the woman's auxiliary to the S. M. A., scheduled for St. Louis, November 13-16, has been cancelled. Mrs. John P. Helmick of Fairmont, auxiliary president, in announcing the cancellation, stated that the action is being taken at the request of the council of the S. M. A., made "because of pressure from the Office of Defense Transportation."

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THE BEDSIDE MANNER

One of the most important characteristics of great men in medicine who have inspired and deserved our admiration and affection is the "bedside manner." The term as used here connotes depth of learning and sincere concern for the patient, which is the only sound basis for confidence in a doctor. This "manner" has been and is seen at its best in consultation in the sickroom, for there the consultant observes meticulous consideration for his fellow practitioner, whose guest he is for the moment. There is nothing finer than this relationship in medicine.

Recently a Washington physician was quoted as saying that something should be done to prevent physicians from suggesting to patients that they have been carelessly or badly treated at the hands of a previous attendant. The implications in this statement are that doctors are as a rule unfair to each other. It can be safely said that rarely does a physician with malice aforethought disparage another practitioner in the presence of a patient. On the other hand, physicians have not always been as diligent as they might to explain to a patient coming to them from another doctor that a sense of dissatisfaction or distrust may be based on misunderstanding or a faulty evaluation of results. Withholding a judiciously favorable comment on a colleague may really leave a physician open to serious criticism. For, as Robert Louis Stevenson observed, "One may sit in a room and listen in silence while a friend is attacked and leave the room having more completely condemned his friend than if he had spoken."

It is not meant to suggest that malpractice should be condoned or defended but merely that physicians be extremely cautious and fair toward a previous attendant when they find themselves being credited with exceptional ability and judgment. Indiscretion is usually a boomerang. It would be too

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bad if it injured only the sender. Not infrequently when badly aimed or well-aimed with bad intentions it may become a dangerous instrument, resulting in damage to the patient, the doctor, and the entire medical profession. A boomerang might just as well be swung gently and carry a message of good will, to restore confidence to a doubting and unhappy patient, returning to give the sender a feeling of satisfaction in a deed well done.—*J. W. L. in Med. Annals, District of Columbia.*

QUALITY OF MEDICAL CARE IMPROVES

In 1912 the average hospital stay for appendicitis was eighteen days; now it is eleven days. The vaerage course of lobar pneumonia has been reduced from weeks to days. The case fatality of epidemic meningitis in 1910 was 80 per cent; in 1935, 30 per cent; today it is 5 per cent. These are only examples of the general improvement in the quality and effectiveness of medical care, which in turn make possible readjustment of insurance rates to the point at which they are within the reach of the average worker in a sound actuarial basis.—*Ernest E. Irons, M.D., in J.A.M.A., July 29, 1944.*

POLIO HITS RURAL AREAS IN 1944

Poliomyelitis shows a great perference for country folks, and the great majority of its victims come down in the summer months.

The North Carolina county from which the largest number of cases have been reported is largely rural. Over the state the distribution is 10 to 12 rural to one urban. And investigation of the few urban cases might disclose that most of these originated in the country.

So it is seen that, in these particulars, poliomyelitis does not behave like diseases known to be communicable by casual contact, but does behave like a disease known to be communicated by an insect vector; viz., yellow fever.

It would certainly be worth while to protect ourselves and our children so far as possible against contacts with flies—green flies, blow flies, stable flies, house flies, horse flies, deer flies—during the existence of an epidemic; indeed it would be the part of wisdom to provide this protection at all times. And it is plain that if any fleeing is to be done, the part of wisdom would be to flee from country to city.—*So. Med. and Surg.*

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MUST CORRECT WEAK SPOTS

The peril through which we are passing has brought home to every doctor the knowledge that there are many weak spots in the present system of medical practice. Many of these weak spots are the result of our own actions, and they can and must be corrected. We must not lose sight of the fact that ours is one of the learned professions, engaged in the humanitarium task of treating and of preventing disease. As such, we have now and may always expect the good will and respect of our patients and friends, who constitute the public. When we cease to conduct ourselves as members of a profession, we may expect to lose the good will of the people.—*J. T. Oliphant, M.D., in J. of the Indiana St. Med. Assn.*

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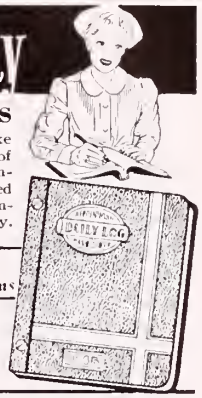

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GUIDE DOGS FOR THE BLIND

There is much interest in the matter of guide dogs, the public generally having the idea that every blinded person should have one. Experience shows, however, that only about 10 per cent of the blind can use dogs advantageously. Many blinded soldiers will develop the ability to get about with the minimum of assistance. With a skillfully used cane they are inconspicious and unencumbered. Some individuals do not like dogs; others are temperamentally unfitted for canine companionship. It is important to have determined the type of work to be done and whether a guide dog will be practical and compatible with the future choice of a job . . .

Private guide dog agencies have agreed to provide dogs to blinded soldiers either gratis or at nominal cost. It appears that the facilities of these agencies will be adequate to meet all anticipated needs and that governmental aid in supplying dogs will not be required.—*Brig. Gen. Charles C. Hillman, USA, in J.A.M.A., June 3, 1944.*

CANCER OF THE LARYNX

Each year 1,500 men and women in the United States die of cancer of the larynx; 5,000 suffer from this disease at any given time. Early cancer of the larynx is curable in 80% of the cases by a limited operation or by a short series of radiation treatments.

Hoarseness is an early symptom in at least 95 per cent of the cases. Examination of the larynx with a mirror easily establishes the presence of a growth and biopsy readily settles the diagnoses. The outcome depends on early diagnosis and prompt treatment.—*Max Cutler in Bull. Am. Soc. for Comtrol of Cancer.*

EXERCISE FOR ASTHMA

At times physicians seem startled when it is mentioned that exercise of any kind may be attempted in the treatment of asthma. However, when some of the physical aspects of the condition are considered it is not inconceivable that remedial exercise may be of definite benefit. Of course, no claim is made that these physical procedures remove the cause of asthma, but they may partially control the condition or assist in compensating for it.

Many more controlled studies on the use of remedial exercise in asthma need to be done. Since there is enough evidence to indicate that such procedures may be of value, more physicians should

make an effort to obtain a better knowledge of the procedures. To make an adequate study of the procedure will require well-developed technics, otherwise use of remedial exercise for asthma may fall into ill repute and have to be condemned, for if the exercise is done improperly, more harm than good may be done.—*Archives of Physical Therapy.*

NATIONAL DRUG NAMES RESEARCH HEAD

The appointment of Dr. Gustave J. Martin as research director of The National Drug Company has been announced by Mr. A. B. Collins, president.

Doctor Martin has been serving as assistant director in charge of the division of chemistry at the Warner Institute in New York City. He is a member of numerous scientific societies and has published more than 50 papers in various scientific journals.

MEAD JOHNSON & COMPANY CONTEST

Through the cooperation of Mead Johnson & Company, war bonds in the amount of $40,000 are being offered to physician-artists (both in civilian and military service) for art works best illustrating the title, "COURAGE AND DEVOTION BEYOND THE CALL OF DUTY."

The contest is open to members of the American Physicians Art Association, and full details may be obtained from Dr. F. H. Redewill, Secretary, Flood Building, San Francisco, California.

UPJOHN FEATURES "COUNTRY DOCTOR"

"The Country Doctor" will be featured in the forthcoming Upjohn window display, another in a long series of displays produced in honor of the medical and drug professions.

The centerpiece of the display is the Norman Rockwell painting which has come to be called "The Country Doctor." It depicts a mother and three children in a doctor's office. This is the painting that won such acclaim from professional men and laymen alike when it was first shown in an Upjohn window display several years ago. It will appear soon in drugstores all over the nation.

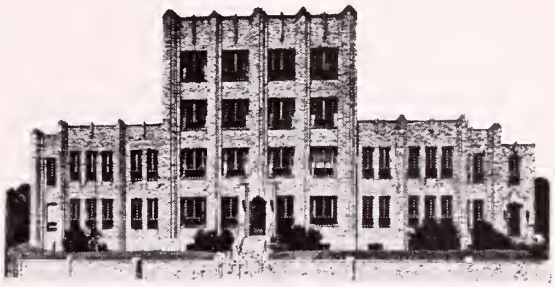
OVERWEIGHT PREJUDICIAL TO LONG LIFE

According to Dr. Theodore G. Klumpp, president of the Winthrop Chemical Company, Inc., it is biologically possible for many of our children to live in good health for 130 years. Addressing the annual meeting of the American Chemical Society, in New York, September 14, Doctor Klumpp stated that the attainment of this goal will be found in medicinal chemistry.

"The fact that some individuals have been known to have lived for as long as 130 years," Doctor Klumpp declared, "means that when we learn more about the factors that influence longevity more may be brought to that ripe old age. Indeed, those who might ordinarily obtain such long life may be able to live even longer. In the animal kingdom the life span of a specie is five or six times longer than its period of maturation. On that basis the normal span of man should be from 125 to 150 years."

Doctor Klumpp expressed the opinion that overweight is a factor that is highly prejudicial to long living. Few individuals who are much overweight," he said, "live to a ripe old age."

THE MYERS CLINIC HOSPITAL



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TREATMENT OF DIABETES MELLITUS BY "SINGLE INJECTION" METHOD*

FRANKLIN B. PECK, M. D.**
Indianapolis

THE first few years following the discovery of insulin were occupied with the development of methods of adapting the new principle to the drastically restricted diets in use at that time. It was no longer necessary to impose the rigors of starvation on diabetic patients, and soon there was widespread adoption of diets that contained more liberal amounts of carbohydrates and less fat. The size of individual doses of rapidly-acting insulin was readily determined by the demands created by meals, and the main difficulty lay in the necessity for several daily injections of insulin and the tendency toward nocturnal hyperglycemia in severe cases. The introduction of protamine insulin signified another great advance, characterized by Joslin as the "Hagedorn era," and since 1936, the attention of clinicians treating diabetes has been focused largely on methods of dietary distribution by which the slow but prolonged effect of modified insulin preparations could be advantageously utilized and balanced successfully over the whole twenty-four hour period. In the main, success has depended upon skillful balancing of diet in relation to insulin effect rather than upon adjustment of insulin dosage in respect to individual meals. Rearrangement of the dietary allotment for different meals has been widely practiced, a common diet prescription being the division of the total into one-fifth, two-fifths, and two-fifths, or twenty, thirty, and forty per cent at breakfast, dinner, and supper, respectively, with the remaining ten per cent given at bedtime to prevent too drastic lowering of the nocturnal blood sugar level. In spite of excellent results in the majority of cases, there has remained a severe type of diabetes that has necessitated administration of multiple daily

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*Summary of an address before the Cabell County Medical Society, Huntington, West Virginia, March 9, 1944.

**From the Lilly Research Laboratories and Diabetic Clinic, Indianapolis City Hospital.

doses of insulin and protamine zinc insulin before satisfactory control over both day and night periods can be attained.

Anyone familiar with the wide variation in diet prescriptions used in various prominent clinics of this country cannot but be impressed with the utter lack of uniformity in methods. For instance, the carbohydrate content of the diet ranges on the average from 100 Gm. to as much as 250 or even 300 Gm. per day. One prominent clinic prescribes diets which are equivalent to normal requirements in calories; others make no attempt to duplicate normal nutritional requirements except in so far as mineral and vitamin components are concerned. The only constituent of the diet that approaches uniformity is the protein, practically all diabetic diets containing at least 1 Gm. of protein per kilogram of body weight. In the face of such variability in total content and distribution of one of the most fundamental factors governing the requirement for insulin, the basic food load, it does not seem logical to expect that any single standardized modification of insulin can be developed which will be capable of providing the desired twenty-four hour control with a single dose. An insulin modification can be standardized, but the individual patient and his diet prescription cannot.

SEVERAL EXPEDIENTS

In order to meet these widely varying demands, one of several expedients may be chosen:

1. Administration of a basic dose of protamine zinc insulin, and separate supplementary doses of insulin.
2. Use of a whole series of standardized preparations having their range of time-activity between the rapid but brief effect of insulin and the slow but prolonged action of protamine zinc insulin.
3. Prescription of adjustable extemporaneous admixtures of insulin and protamine zinc insulin "tailor made" to fit the individual requirements of each case.

The first alternative imposes on the patient the annoyance of multiple daily injections at inconvenient times. The second could only result in untold confusion among patients, physicians, and the drug trade; it would necessitate multiplication and duplication of retail and wholesale stocks with attendant slower turnover and greater hazard of deterioration, and in all likelihood would eventually so complicate the marketing of insulin-containing preparations that increased cost to the consumer would result. The third procedure, although it sounds difficult and complicated is in reality simple, and furthermore is capable of providing an easily adjustable effect with but a single daily injection. Any patient who can be taught to take one dose of insulin into his syringe can just as readily withdraw two doses and mix them before injection, obtaining both a prompt and prolonged effect.

NEW MODIFICATIONS PROPOSED

During the past several years a rather large number of new modifications of insulin have been proposed. The possibilities for others are practically unlimited, including such widely different modifying agents as colloids, lipoids, organic and inorganic compounds, dyes, and the basic protein precipitants such as the numerous protamines and histones. Some of these modifications have been studied clinically, and several have even been marketed in Europe. They are, and must always be, fixed, standardized combinations, and as such will fit almost perfectly a certain group of patients having requirements that are satisfied by that particular product's rate of onset and duration of activity.

The expert who is specially qualified in the treatment of diabetes is capable of obtaining an almost perfect result with any single modified insulin preparation by proper manipulation of dietary intake and distribution. This is true of protamine zinc insulin,[1] it is true of clear protamine zinc insulin,[2] of histone zinc insulin,[3] of globin insulin,[4] and of buffered or unbuffered combinations of insulin and protamine zinc insulin, both premixed and mixed extemporaneously in the syringe.[5] If all of the 800,000 persons with diabetes in the

United States were or could be treated by specially qualified experts, the problems of insulin therapy might well be solved by a properly graduated series of marketed modifications. Probably three-fourths of these patients, however, are being treated by the general practitioner, who has neither the time, the facilities, nor the inclination to learn to handle such a series of products with facility. That he can, with the aid of ordinary routine observations, learn to balance a patient satisfactorily with a suitable mixture of insulin and protamine zinc insulin has been demonstrated over and over again on the medical wards of the Indianapolis City Hospital by the intern staff. This technic is easy.

IDEAL PREPARATION OF INSULIN

What constitutes the ideal preparation of insulin? Certain criteria stand out. Its time-activity should correspond as closely as possible with normal physiological needs. The most difficult period of the day is the morning. For years before the advent of protamine zinc insulin I advocated the unequal division of food in the meals, giving a small breakfast, a larger lunch, and a still larger evening meal, to take advantage of the Hamman-Hirschmann effect. I have given it up because physicians and, now that the personnel problem is so acute, even dietitians, do not wish to give or are not capable of giving the time to the individual calculations necessary. It is especially difficult now in most hospitals to provide individual feedings at different times of the day and night. Patients must be dieted in as nearly a production line fashion as possible, and the easiest way to standardize diets for the diabetic group is to calculate three equal meals, each representing one-third of the day's total intake. Our ideal insulin then, should be capable of metabolizing such a diet satisfactorily with a single daily dose without allowing sugar wastage after meals, and in addition it should be capable of maintaining sufficient action over the night to permit the patient to awaken with a blood sugar level within normal bounds. Hypoglycemia should be avoided without recourse to supplementary feedings at odd hours of the day or night. Except for the disadvantage of several daily injections regular insulin could satisfy these requirements. Experience has demonstrated that the largest dose of insulin is required before breakfast, so any insulin preparation having only a twenty-four hour effect obviously must be capable of releasing its active principle rapidly enough during the first hour or two after it is given to prevent hyperglycemia after breakfast. The only alternative is a preparation having an action over a longer period than twenty-four hours so that it exerts some overlapping effect into the next day.

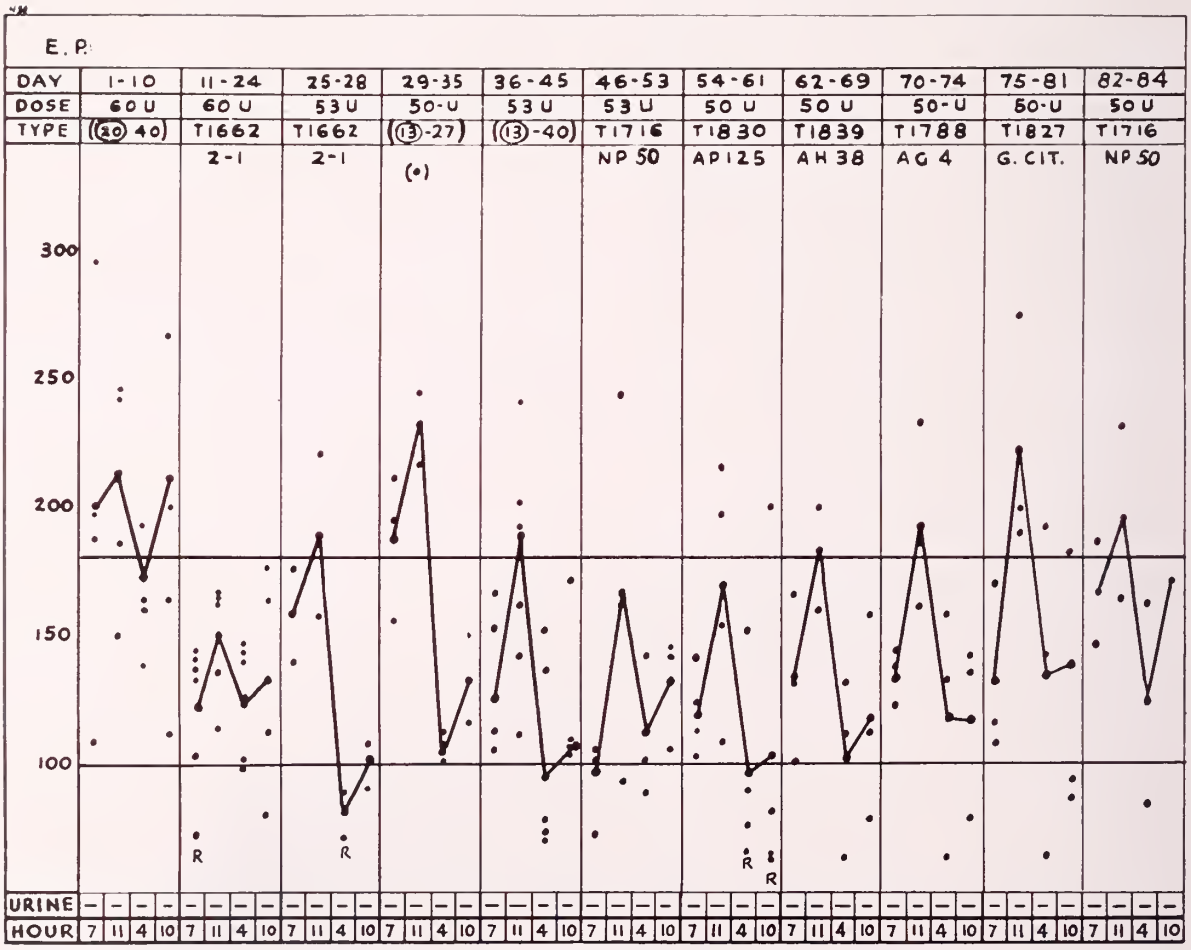
PRINCIPLES ALTERED

More than two years ago at the Indianapolis City Hospital, we altered our principles of diabetic regulation. Instead of attempting to prescribe the individual's diet to suit the action of standardized insulin preparations, the opposite course was adopted,—that of adjusting the insulin preparation to fit the individual circumstances, which were standardized as much as possible. In other words, we attempt to fit the insulin to the patient instead of the patient to the insulin. This is accomplished by prescribing three equal meals, no supplementary feedings, and by the same laboratory criteria as previously required to establish control with insulin and protamine zinc insulin when given in separate doses. Routine examinations include fasting and postprandial (P. M.) blood sugar determinations on two days of each week, with daily routine Benedict tests of the four period urine specimens — fasting, morning postprandial, afternoon postprandial, and bedtime. In order to provide a base line for comparison of methods, each case is first controlled as well as possible with separate doses of insulin and protamine zinc insulin, no matter how many doses are required. When this has been accomplished, the total dosage is given before breakfast each morning in the form of a suitable admixture in a single dose. If postprandial levels rise unduly, a greater proportion of insulin is needed in the mixture;

if daytime reactions occur, less insulin is prescribed. Just as is the case when giving protamine zinc insulin separately, the dose of this component is governed by the blood sugar level as determined before breakfast. The essentials of the method are itemized in table 1. Until familiar with the technic it is helpful to refer to a table of approximate content,[6] or to keep in mind the theoretical amounts of available quick insulin shown in table 2.

For over a year there has been no attempt to select cases thought to be particularly suitable to this method. Every case is routinely managed in the same manner, with the exception of those having complications, in which event the shift to a single injection is not ordinarily made until the complication has subsided. If a patient who is already taking a mixture develops a complication, or requires surgery, the basic dose remains the same and, if necessary, supplementary doses of unmodified insulin are prescribed during the interval. We do not hospitalize outpatients for readjustment, and have no hesitation in changing over in the outpatient diabetic clinic. The outpatients keep records of the four period urine specimens obtained under home conditions. On the morning of the visit to the clinic a fasting blood sugar level is ascertained, the nurse gives the injection, and breakfast is served in the hospital diet kitchen. A postprandial blood sugar level is determined two

Blood sugar curves observed under controlled conditions, varying only the type of insulin used.



Solid line represents the average. Figures in parenthesis are admixtures in syringe, the dose of protamine zinc insulin is encircled. Specially prepared modifications are identified by lot number T-1662, 2 parts crystalline insulin, 1 part protamine zinc insulin premixed in vial; T-1716, buffered protamine zinc insulin containing 0.5 mg. protamine per 100 units of insulin; T-1830, clear (acid) protamine zinc insulin (protamine 1.25 mg. per 100 units of insulin); T-1839, clear Histone zinc insuln (histone 3.8 mg. per 100 units of insulin); T-1788, globin zinc insulin (globin 4 mg. per 100 units of insulin); T-1827, globin zinc insulin (globin 4 mg. per 100 units of insulin with 1.25 mg. citric acd).

hours later in the diabetic clinic. In the case of patients who are undergoing special studies more frequent observations are made as indicated in figure 1. Such patients are maintained under stable conditions for at least several weeks before instituting special observations.

Of more than 150 patients who have been observed under these conditions in the last two years, only 3 have been changed back to the separate injection method on account of poor results, this change being necessitated chiefly because of conditions which would not permit of cooperation. A number of these patients have been maintained on special, ready-made modifications for purposes of observation and comparison. Diabetic control has been at least equal to, and usually superior to that accomplished with multiple injections. In some instances spectacular improvement has resulted. One patient, a woman who has had diabetes for eighteen years, had never been sugar free. On her seventeenth hospital admission, over a year ago, it required three doses consisting of 80 units of protamine zinc insulin, and 40 units of insulin, both given before breakfast, and 20 units of insulin before supper to maintain normal fasting and postprandial levels and aglycosuria. This

Table 1—METHOD

Recent cases and those not previously treated

I. (a) First day—(10) units protamine zinc insulin
(b) Increase daily by (5) to (10) units until urine is nearly sugar-free on arising, or until blood sugar (fasting) approaches 100 mg. per 100 cc.

II. If glycosuria and hyperglycemia persist after meals, add supplementary doses of insulin varying with Benedict test:

e.g.	YELLOW	ORANGE	RED
	5 units	10 Units	15 Units

III. Replace multiple injections with single dose admixture:
(a) Substitute total with 2:(1) mixture
(b) If daytime glycosuria and hyperglycemia, increase insulin content, e.g., 3:(1).
(c) If postabsorptive (fasting) glycosuria and hyperglycemia, reduce amount of insulin in mixture, and increase protamine zinc insulin, e.g., 3:(2).

Patients taking insulin

I. Replace total daily dosage with three-fourths as much protamine zinc insulin.
(a) Increase dose until urine is sugar-free on arising.

*The criteria for adjustment of admixture are identical with those governing separate doses—the proportion of insulin to protamine zinc insulin differs.

Table 2—CONTENTS OF ADMIXTURES

UNITS		PARTS		Mg. Protamine in Mixture	Approximate Theoretical Units* in Admixture	
Insulin	P.Z.I.	Insulin	P.Z.I.		Quick	Prolonged
-	100 -			1.25		97.5+
25 -	75 -	1	3	.936	10	90
33 1-3	66 2-3	1	2	.83	15	85
50 -	50 -	1	1	.625	27	73
60 -	40 -	3	2	.50	39	61
66 2-3	33 1-3	2	1	.417	50	50
75 -	25 -	3	1	.313	63	37
80 -	20 -	4	1	.25	68	32
83 -	17 -	5	1	.208	74	26

*Prompt and prolonged effects are merged and do not represent the identical time-activities of standard insulin and protamine zinc insulin.

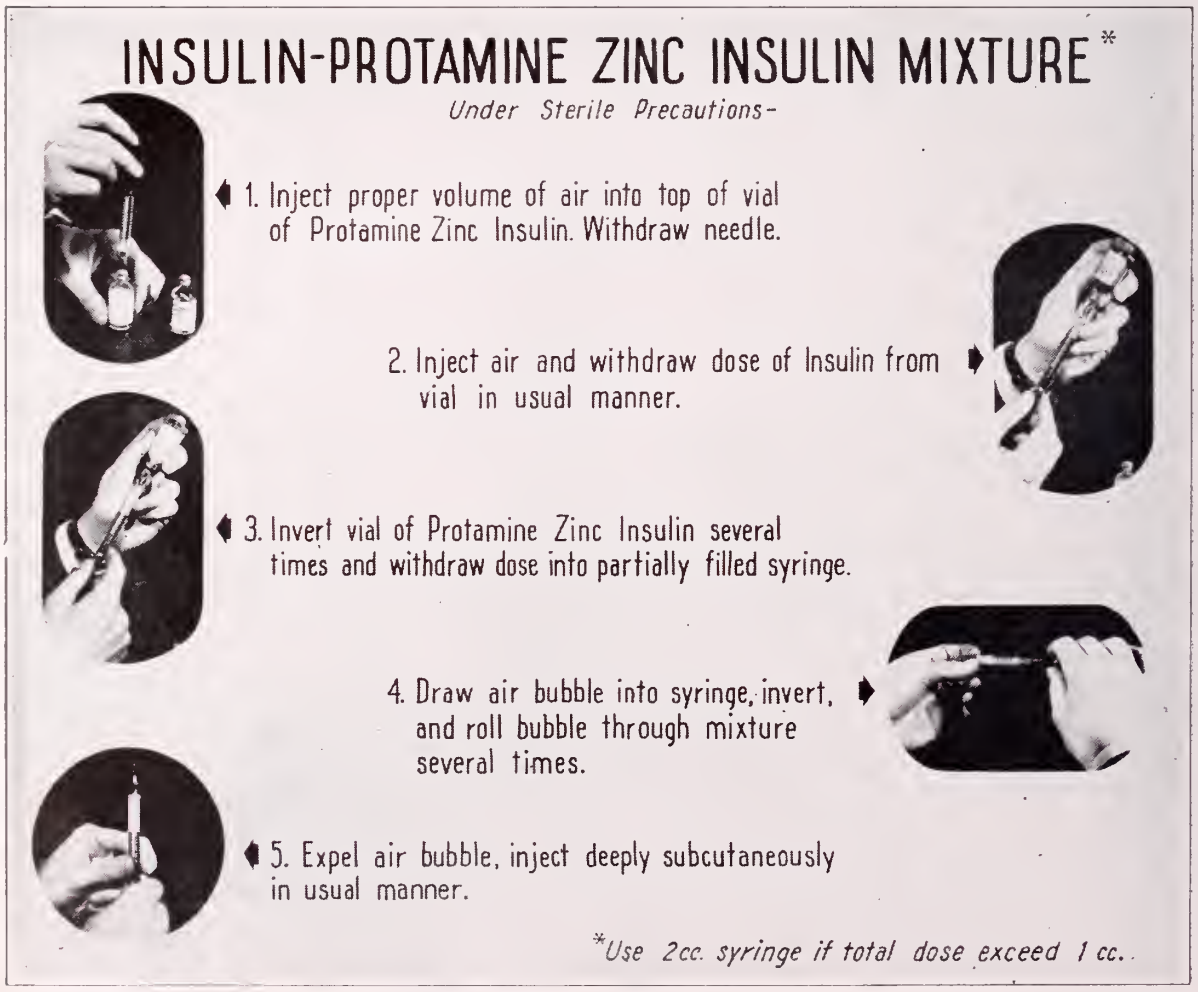
Table 3—COMPARISON OF STANDARD METHOD WITH EXTEMPORANEOUS MIXTURES
(Averages AFTER Control Established)

	Standard—Separate Injections	Mixture—Single Injections
Total Dose, Units.....	49	42
Blood Sugar, Fasting.....	155	108
Blood Sugar, Postprandial 11 a.m.	186	160
Blood Sugar, Postprandial 4 p.m.	157	116

patient was discharged taking 100 units of a 2:(1) mixture (2 parts of insulin to 1 part of protamine zinc insulin). She has remained sugar free without reactions, and with gradual reduction of dosage until she now takes but 45 units each morning. Twenty-five summaries of case records (omitted for lack of space) are compared in table 3 as further examples of typical results.

In general the proportions of insulin to protamine zinc insulin have varied with the total insulin requirement although this is not an inflexible rule. Usually, patients who require less than 40 units daily have done well with 3:2 mixtures, (3 parts of insulin to 2 parts of protamine zinc insulin); for those who need between 40 and 50 units daily, the 2:1 mixture is usually suitable, while the more severe cases who need in excess of 50-60 units each day have required 3:1 or even rarely 4:1 combinations. The largest single dose has been 160 units in a patient having Albright's syndrome and insulin resistance. This patient has since taken 140 units daily for the past several months.[7] Usually, there is some apparent economy in units, but this is owing to improved tolerance under better conditions of control. We have not observed patients who required more insulin unless they were previously receiving inadequate dosage.

The admixture of insulins is a method which is easy to demonstrate but difficult to teach by word of mouth. Patients should be actually shown how to make their mixtures. The only new feature to be learned is the drawing in of an air bubble and the rolling of it through the syringe to obtain admixture of the two components. Since all the daily doses



are being combined into one single injection, the 80 unit per cc. concentrations are most suitable in order to keep the bulk of injections as small as possible. Preparations of the same manufacturer should be used so that results will be kept constant. Iletin Syringe No. 350, having 2 cc. capacity calibrated to 160 units has been developed for this particular purpose. Figure 2 lists the actual steps involved in making a mixture.

SUMMARY

It has been emphasized that different patients, being treated by different dietary regimens containing various proportions of carbohydrate, protein, and fat cannot be expected to respond in a like manner to any single standardized modification of insulin, no matter what modifying agent is employed. The suggestion is made that it is simpler to adopt a standard dietary system which does not necessitate special feedings, and to readjust the insulin to the case individually than it is to attempt to adjust the patient's condition to a fixed preparation of insulin. The results obtained by such a technic have been briefly summarized, and the method described. The insulin component of the admixture is determined by postprandial blood sugar levels and the amount of daytime glycosuria, while the amount of protamine zinc insulin included in the single dose is governed by the blood sugar before breakfast, or the amount of sugar in the urine specimen on arising in the morning. A few unselected case summaries have been included as examples.

Example: Suppose the dose is to be 30 units of insulin and 15 units of protamine zinc insulin (2:1 mixture). The total is 45 units. This mixture might be made from either U-40 or U-80 insulin and from protamine zinc insulin containing either 40 or 80 units per cc. Use only one concentration or the other. Do not attempt to mix different concentrations together. The bulk of large doses should be reduced to 1 cc. or less wherever possible by using the 80-unit-per-cc. products. First withdraw the clear insulin up to the 30-unit mark in manner described on page 346, then draw into the syringe enough protamine zinc insulin (15 units) to complete this dose, up to the 45-unit mark. *Always withdraw the clear insulin first* as it will not matter if a drop of it enters the vial of protamine zinc insulin. However, if a small amount of protamine zinc insulin gets into the vial of insulin, it will cause the clear insulin to become cloudy. Carefully follow each step of the method outlined. A little practice with two used insulin vials which have been filled with water will increase proficiency and accuracy in this technic.

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ADVANCES IN CARDIOLOGY SPECTACULAR

Heart disease in the year 1942 was the cause of 386,141 deaths in the United States. In no field of medicine have the advances in accuracy of diagnosis been more spectacular than in cardiology. These advances have been due in no small measure to the employment of instruments of precision, particularly the electrocardiograph. It is astonishing, however, how accurate diagnosis can be made employing only the procedures of inspection, palpation, percussion and ausculation. While the electrocardiogram has been of the utmost value in explaining, for instance, the mechanism of various types of arrhythmia, yet these types of arrhythmia can be diagnosed with a great deal of precision by simple methods of examination.—*Ralph H. Major, M.D., in New Orleans Med. and Surg. J.*

MEDICINE IN THE SOUTH PACIFIC*

By CAPTAIN ALPHONSE McMAHON, (MC), USNR
Bethesda, Md.

THE AUTHOR

Captain McMahon, (MC), USNR; formerly senior instructor in medicine, St. Louis University School of Medicine; Past President of the St. Louis Medical Medical Society; Past Vice-President of the American Medical Association; American Board of Internal Medicine.

THE practice of medicine in the military activities of the South Pacific is concerned with a host of new and unusual problems. The difficulties accompanying acclimatization to the tropics, the adjustments to new foods, the mental reactions attendant on exposure to the multitude of insects and to the tropical diseases themselves, serve as a challenge to the professional training, the ingenuity and the perseverance of the medical officer.

The setting-up of a military project necessitates certain fundamental sanitary procedures in order to avoid the introduction and spread of disease among the personnel. The practice of medicine may give place to the immediate practical application of sanitary principles and the medical officer may find that he is a sanitary officer long before he is called upon to treat disease. Efficiency in these matters will be well rewarded.

The adaptation to climatic heat is a complex physiologic process and varies with each individual.[1 2] It is impossible to establish fixed rules for activities in the tropics that may be applied equally to all cases. The physiologic effects of a hot climate are multiple and involve practically all systems. The body temperature is slightly increased, though seldom above 1½ degrees (F.) and remains elevated as long as the individual resides in the tropics. It may drop to normal in the fully acclimatized person but rises above normal after strenuous exercise.

A reduction in blood pressure often occurs, affecting both systolic and diastolic pressures. The pulse rate is variable and may be reduced. It may be increased or may remain normal. Exercise, however, produces a rapid rise in the rate. The heart is burdened, following prolonged exposure to heat, in an effort to maintain the circulation.

The basal metabolism is lowered and there is a definite decrease in the function of the endocrine glands affecting chiefly the thyroid, the adrenal and the gonads. This decrease in function may be primarily responsible for the feeling of lassitude so common among residents of the tropics.

The blood volume may be increased but there is no marked change in the formed elements of the blood. The blood sugar may be low and a slight alkalosis is invariably present.

Appetite and digestive capacity are increased in the early days of tropical residence but both decrease with a prolonged stay in the tropics. Diarrhea is common at first but is soon followed by constipation.

Urinary excretion is diminished due to the great loss of fluid by sweating. The loss of sodium chloride in the sweat is marked in the early days of adjustment but decreases with acclimatization.

The nervous system shows an early stimulation with a later depression. Mental irritability is common among the long standing residents.

The depressing influence of the tropical climates is a well-known fact. The relatively high temperatures, the constantly high humidity and the absence, in many localities, of air currents interferes seriously with the cooling mechanism of the body. The great loss of fluid and sodium chloride creates

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serious disturbances of the physicochemical balance of the individual.

It is difficult and, at times, dangerous for men coming into the tropics to work continuously for long periods of time in the almost vertical rays of the sun and in an atmosphere of high humidity. At the zenith the sun's rays are fifteen times stronger than when the sun stands 10 degrees above the horizon and the rays, thus, penetrate to a degree unknown in temperate zones where the radiation is absorbed by the intervening atmosphere.[1] Fatigue appears much earlier than it does when similar work is performed in temperate zones and this necessitates the introduction of shorter work periods and longer intervals of rest during the early days of exposure to the new climate.

The medical officer must have a thorough understanding of these effects of the tropical climate in order to supervise intelligently the activities of the personnel so that acclimatization, with consequent greater efficiency, may be achieved in a relatively short time and with the minimum of discomfort to the individual.

MAJOR PROBLEMS OF SANITATION

One of the major problems in sanitation encountered in a tropical base hospital activity is the control of mosquitoes and flies. The use of bed nets and head nets as mosquito protection was instituted immediately on arriving. The flies were numerous, persistent and undoubtedly served as a most important source of the spread of gastrointestinal diseases through contamination of food and messing gear. An effort was made to control this hazard by careful screening of galleys, mess halls, and latrines. This was effected as quickly as possible, consistent with the supply of necessary screening material.

The disposal of garbage at safe distances from the hospital was of assistance in the fly control program. In the later stages of the activity the garbage was disposed of at sea by means of special barges. Refuse was burned daily. All cattle were ordered removed to areas at least a mile away from the hospital sites. In spite of all these precautions, the ubiquitous flies persisted in their disturbing and dangerous efforts.

The establishing of a safe water supply was also of great sanitary importance in the prevention of gastrointestinal diseases. In many of the tropical areas, rain water collected from the roofs of houses and drained into tanks serves as the only source of supply. The inadequacy of this method of supply for a large activity is apparent. The bulk of the water used in the early days was obtained from streams or rivers, chlorinated in a trailer tank and then delivered to the outlying activities. All drinking water was boiled before being used. At the permanent hospital a modern water system was installed by which water, obtained from a river some distance from the hospital, was chlorinated, filtered, and precipitated at its source and pumped to the storage tanks on the hospital compound. No contamination was discovered on repeated examinations.

GASTROINTESTINAL DISEASES

One of the most important causes of the spread of gastrointestinal diseases lies in the improper care of the messing gear. Unclean and unsterilized messing gear serves as an invitation to fly contamination. Cleanliness of the gear, effected through the proper installation and use of a sterilizing mechanism, is necessary if gastrointestinal diseases are to be kept to a minimum. The method employed in the early days for this purpose consisted of the simple field method of using three open gasoline drums cut along their length and placed over fires. The water was thus kept constantly boiling. The first drum contained soapy water, the remaining two drums contained clear water necessary for rinsing. The messing gear was put through this process after each meal and immediately before use at the following meal. In the permanent hospital a modern scullery was installed which left less to chance and to the indifference of the men. It was necessary, however, to exercise supervision of this mechanism at regular intervals.

Medical practice was carried on in the early days of the hospital activity, for the most part, in a symptomatic fashion. Facilities for laboratory and x-ray studies were minimal and the clinician was obliged to rely on his unaided clinical experience and judgment. In most instances the effectiveness of such efforts seemed satisfactory. Patients were housed in small private residences, which, in that area, are happily provided with wide verandahs that serve admirably as open-air wards. The refinements of the modern hospital were lacking; but the patients were made comfortable and were supplied with everything necessary for their care.

The practice of medicine was simplified to a degree not thought possible by medical officers accustomed to the complexities of modern hospital practice. The adjustment of these men to the new practice was rapid and adequate. The irritation that arose from the fact that medications habitually used were not available gave way to surprise at the number of drugs and the supplies that were available and a greater surprise at their own ability to adjust psychologically to the use of many drugs previously unused by them. The value of a few fundamental drugs in the medical armentarium was proved on many occasions.

All supplies, medical and non-medical, were used with caution in the early days for all were limited in amount. The uncertainty of obtaining additional supplies soon became evident to all concerned. The activity was not designed for one of wasteful habits. One, so inclined, quickly learned to develop habits of conservation. The education in conservation was valuable to all men participating in the activity.

The health of the personnel under these rather primitive field conditions remained uniformly good. Attention to the primary principles of sanitation, fly and mosquito control, care of messing gear, and an adequate safe supply of water, contributed largely to this healthful state.

The hospital care, adequate as it was in the improvised quarters of the early days, became more efficient with the erection and occupation of the permanent hospital which was of Quonset hut construction. The patients had the advantage of complete laboratory and x-ray facilities. Modern, completely equipped operating rooms, permitted a wide range of surgery. All necessary equipment for the practice of the surgical specialties was also supplied. The wards were clean and bright and a modern laundry supplied fresh linen at all times. The food, while largely of the tinned variety, was supplemented at intervals by fresh meat and fish and later by the addition of vegetables grown on the island under the supervision of the commissary officer. Everything possible was done to make the hospital conform to the high standards of practice maintained by the service hospitals of this country.

It is not possible in the time alloted to discuss all the medical problems encountered in a South Pacific base hospital. The diseases which were encountered represent, perhaps, a fair cross section of the general disease problem in that area. Each locality had its own medical problems peculiar to the area. A composite picture of the entire area can be obtained only when all activities have reported.

DIARRHEA COMMON CONDITION

One of the most common conditions occurring among the men shortly after arriving on the island was a simple diarrhea lasting for two or three days and recurring two or three times a month. In most instances, it was not disabling but it proved to be distressing to many. Almost all of the personnel suffered from this condition at one time or another. The exciting cause could not be determined in all cases but it was felt that the condition resulted from many factors present in the process of adjustment to the tropics.

In addition to the metabolic factor, the excessive eating of the island fruits, which were chiefly of the citrus variety, also may have played a part in these upsets. The personnel, eager to try the new fruits, indulged

too heavily, producing at times unpleasant results.

The psychogenic factors, fear and anxiety, arising from uncertainty as to the outcome of the expedition, could not be underestimated as causes of diarrhea. The significance of these factors is difficult to evaluate but their existence in at least some of the personnel scarcely could be denied. The effect of these emotions on the gastrointestinal functions is well known but, perhaps, not too well understood.

SEVERE GASTROENTERITIS

A more severe gastroenteritis, unquestionably infectious, also made its appearance very early. In this condition the predominant symptoms were fever, malaise, nausea, vomiting, and diarrhea. The stools in some cases were bloody. The constitutional reaction of these patients was often severe and the disease proved to be disabling. Undoubtedly these cases belonged in the dysentery group but it was not possible to confirm this relationship. The persistence of general weakness in some cases, after recovery, added to the belief of the nature of the causative factor. The majority of the cases responded promptly to a simple dietary regimen and to gastrointestinal sedatives.

The organization of the permanent laboratory made it possible to carry out more complete studies on the stools of the patients afflicted with diarrhea. A more specific determination of the etiology of the gastrointestinal disturbances thus could be made. It was also possible in the permanent hospital to isolate more effectively the patients with diarrhea during the diagnostic interval and during the application of treatment.

The incoming cases with severe diarrhea and those cases developing evidence of enteric diseases while on general wards, were placed in the isolation wards until complete studies could be made. These wards were located at some distance from the galley and mess halls and were made as fly-proof as possible. The patients were not permitted to leave the vicinity of the wards except at night to attend the moving pictures which were shown in an out-of-doors theatre. All messing gear was kept on the wards and sterilized there by boiling and by chemical treatment. The latrine danger had been largely eliminated by the use of the chemical tank type of latrine.

This isolation procedure proved very effective in controlling enteric diseases among the personnel and the patients of the hospital. A few minor outbreaks of a Shigella infection were traced to breaks in scullery technique and easily corrected. In a fly-ridden country too much emphasis cannot be placed on scrupulous cleanliness in the handling and serving of food and in the care of all materials concerned with the messing problem.

Bacillary dysentery did not constitute a serious problem but with the exercise of less caution in its prevention this disease might have spread more extensively.[3] There were 53 cases of severe diarrhea, in which Shigella organisms were found. It was not possible to establish the exact species of the organism in the earlier days of the study.

AVERAGE DURATION

The average duration of the symptoms before admission was two days. The onset was usually acute while the symptoms in many patients were severe with marked prostration and intense abdominal cramping. A history of blood in the stools could not be always obtained due to the use of latrines in the field. However, this finding was confirmed in practically all cases on admission to the hospital.

Treatment of the dysentery was initiated immediately if the stool specimen proved to be negative for ova and parasites and presented the characteristics of a dysentery stool. Sulfaguanidine was the drug of choice and was administered orally in the following manner: 3 Gm. was given at the start of the treatment and the dose repeated in one hour. The drug was then continued in doses of 3 Gm. each every four hours, day and night, until definite clinical improvement occurred. This took place in from twenty-four to forty-eight hours in the majority of cases. The frequency of the above dose was reduced to four

times daily and continued until the stools had been normal for from four to five days. The drug was then discontinued for forty-eight hours. If the stool remained normal during this time, stool cultures were repeated every third day until three successive negative cultures had been obtained.

Under this plan of treatment all cases were returned to duty within a reasonable length of time. The average number of days on the sick list was 24.1.

AMEBIC DYSENTERY

Amebic dysentery, which was endemic on the island, was relatively infrequent among the personnel due to the careful treatment of the water supplied to the troops. In our series of 1,740 stool examinations, 47 patients proved to have cysts or trophozoites of E. histolytica. Of this group, 9 patients showed trophozoites alone and all of these cases had symptoms of acute infestation. The cases in whom cysts alone were found, were symptom free or presented a variety of abdominal complaints that were vague and indefinite. At first, these cases were often grouped with the patients of the so-called irritable colon syndrome and classified properly only after repeated stool examinations proved the presence of the cysts.

The cases of active amebic dysentery varied in degree, from the acute disabling type with from fifteen to twenty stools a day, to a mild or walking type of dysentery. The symptoms were present over a period of from one week to many months before entering the hospital. The mild type of infestation caused few constitutional symptoms and the condition seemed well tolerated by the patients. The danger of this relatively symptomless condition, as well as that of the cyst bearer state, particularly in its relation to the transmission of the disease, cannot be stressed too vigorously, more especially when it is present in food handlers.

Treatment of the active cases consisted of the use of emetine hydrochloride given intramuscularly in 1 grain doses for from seven to ten days. Carbarsone, 0.25 Gm., was given orally three times a day for seven days. It was started on the fifth day of the emetine course. The carbarsone was repeated after seven days if the stools were found to be positive. This form of treatment proved to be satisfactory in rendering all cases free of infestation. The average stay in the hospital was 37.5 days.

Hookworm infestation, which has a high endemicity among the natives on the island throughout the area, was also relatively infrequent in occurrence. The majority of cases with stools positive for hookworm ova came to the hospital from outside activities. There were 24 cases with ova in stools, 5 of which presented uncomplicated hookworm disease.

The symptoms present in these cases seldom indicated the underlying condition. The majority of symptoms were referable to the gastrointestinal tract and appeared chiefly as flatulence, irregular bowel function, gastric fullness, and indigestion. Fatigue was often present with a lack of sense of well-being.

The differential blood count showed an eosinophilia which was often the only clue to the underlying condition. The presence of an eosinophilia of over 10 per cent was an indication for repeated studies of stool specimens. Unusually high eosinophilia was seen in some cases. Severe secondary anemia was not present due to the relatively recent acquisition of the infestation.

TREATMENT OF CASES

The treatment used in all cases was as follows: Magnesium sulphate was administered at bedtime and three 1 cc. capsules of tetrachlorethylene were given the following morning on an empty stomach. These capsules were followed in one hour by magnesium sulphate. This procedure was successful in eliminating the ova in most cases. In some cases a second and third course of the drug was necessary.

The irritable colon syndrome, which is often designated as colitis or the spastic colon syndrome, created a difficult problem in diagnosis, treatment, and disposition. These patients constituted a large part of the gastro-

intestinal group and were present in the hospital wards at all times during the activity.

The symptoms present in this condition were seldom clearly defined, but were manifest either in relation to the stomach, the intestinal tract, or to both. Indigestion, both qualitative and quantitative, was common and often associated with gastric distention, eructations, and a feeling of heaviness in the epigastrium. Accompanying these symptoms were vague intestinal pains of a cramping nature with flatulence and general abdominal discomfort. Bowel function was invariably disturbed. Fatigue, sleeplessness and subjective nervousness, often with a sense of apprehension, were present in the majority of cases.

BATTLE AREA CASES

These cases were sent in from the battle areas in most instances. However, a moderate number of cases occurred among the personnel of the island where active psychogenic factors were less likely to play a part. The etiologic basis for this condition was not always evident nor was it easy to establish. It was felt that the psychogenic factors of fear, anxiety, and apprehension occurring in men of limited emotional stability were largely responsible for the disturbed function of the gastrointestinal tract.

The presence of symptoms simulating those due to organic diseases or due to parasitic infestation of the gastrointestinal tract, necessitated careful x-ray and laboratory studies of the condition in order to establish its functional nature. It cannot be stressed too strongly that the stool examination should be repeatedly negative before a patient is classed with the functional group of gastrointestinal diseases.

The treatment of these functional gastrointestinal disturbances was unsatisfactory. A non-irritating diet, not always easy to obtain, mental diversions with new interests and an adequate psychotherapeutic regime, are the essentials of successful treatment. Psychotherapy probably was the most important part of the treatment. In many cases the psychotherapy consisted of reassuring the patient that a complete examination revealed that no active disease of the gastrointestinal tract was responsible for his symptoms. This information given to those unduly concerned about themselves was often sufficient to abolish their fears.

The difficulty in handling these cases at an advanced base hospital and the necessity for prolonged treatment with adequate neuropsychiatric control in many cases made it necessary to evacuate many of these patients to areas outside of the active war zone. This move in itself, freeing the man from the possibility of an immediate return to the area in which the condition made itself manifest, was often the only factor necessary to restore the gastrointestinal function to a normal state.

The occurrence of peptic ulcer was not common although it has been reported from other areas. The ulcer syndrome was present in many of the patients classified as cases of irritable colon but x-ray confirmation of the ulcer could not be obtained. The response of many of these cases to a dietary regimen consistent with an active ulcer may have given justification to a clinical diagnosis of peptic ulcer in spite of the negative x-ray findings.

LATENT CHRONIC PEPTIC ULCERS

The possibility of the reactivation of latent chronic peptic ulcers under field conditions is well known. The living conditions, which are varied, tense and irregular, together with the field rations, are not designed for the ulcer patient. The emotional state arising from continued fear and the effect of prolonged physical and mental exhaustion on the physicochemical balance of the individual are additional predisposing factors. It is not surprising that under these conditions a latent ulcer becomes active or that a fresh peptic ulcer may appear.

Acute infective jaundice,[4] with symptoms similar to those accompanying catarrhal jaundice, was present in 320 patients. The majority of these cases came to the hospital from outside areas. The clinical manifestations were seldom severe and the jaundice

persisted from two to four weeks. The entire course of the disease lasted from six to eight weeks with no residue of damage to the liver.

The treatment of these patients consisted of a high protein, high carbohydrate, and low fat diet. Multiple vitamin tablets were liberally supplied. Rest in bed was enforced until the icterus index was less than 20 units.

Pneumonia[5] was not a serious menace to the health of the personnel. The relative infrequency of this disease was due in all probability to the tropical climate, the out-of-door life, and the absence of marked weather changes. The native population has a high incidence of pneumonia which was highly fatal before the introduction of sulfatherapy.

There were 42 confirmed cases of primary atypical pneumonia. All cases showed a mild clinical course, and there were no deaths. The average number of sick days was 20.

FUNGUS DISEASES RESISTANT

Fungus diseases, more commonly involving the feet, legs, and hands, were resistant to the accepted forms of therapy. These lesions were distressing to the patients and, when severe, proved to be disabling. The excessive sweating which kept the body continuously moist, prepared the ground for the introduction and spread of the fungi. Infection of the areas of involvement was frequently seen and was responsible for much of the disability.

Heat rash, the so-called "prickly heat", of varying degrees, was a troublesome accompaniment to the tropical existence. It was more irritative than serious. In the more severe manifestations it assumed the form of a lichen tropica with a secondary dermatitis which reacted poorly to treatment. Frequent short exposure to sunlight was beneficial in these cases.

Bronchial asthma and other allergic manifestations were of frequent occurrence. The basis of the allergies responsible for the attacks could not be determined in the majority of cases. The asthmatic attacks occurred in some patients with a previous history of allergic phenomena of one type or another and appeared in others who gave no antecedent history.

The humidity unquestionably played some part in the persistence of the asthmatic state and its accompanying bronchitis. The response to treatment was unsatisfactory is most cases and the continuance of the attacks interfered seriously with the execution of duties.

The malarial problem of the islands has been discussed at great length in publications on this subject. The limitation of time will not permit us to review this subject in this presentation.

SUMMARY

Medical practice in the South Pacific, as can be seen from the foregoing, must, of necessity, be a combination of preventive medicine and therapeusis.

It is no different in essence from the practice of medicine in more civilized countries, except for the treatment of the diseases peculiar to the tropics and for the fact that in the tropics the medical officer is not only a therapist but must also serve as his own health officer. In civilization the practitioner is free from the burden of this latter responsibility.

The medical officer is motivated in his efforts to control disease by humanitarian reasons and by military exigencies. His responsibility is, accordingly, doubled. The problems that exist in the prevention of the disease peculiar to the tropics, are not insurmountable if the fundamental principles of sanitation and insect control are instituted and maintained at all times. The break in the continuity of protection, arising either from carelessness or overconfidence, often due to the absence of disease in the command, is the factor that may result in the introduction of disease to that command.

The war against the disease-producing elements of the tropics is constant and never-ending, requiring of the medical officer, patience, persistence, imagination and courage. He cannot be perturbed or dismayed by occasional failure. Perfection in the control of all diseases among the military personnel sta-

tioned in disease-ridden areas never has been completely achieved. The idealist in disease control work strives earnestly for this as a goal.

If the majority of the personnel of a given command can be kept reasonably free of disease and at their duties so that the success of the military activity is not impaired and if, by modern methods of therapy, the medical officer is able to restore his men to health and thus to prevent permanent disabilities, he may feel that he has done his duty well and that he has made his contribution to an early termination of the war.

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TROPICAL DISEASES -- ETIOLOGY AND EPIDEMIOLOGY*

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"No spot on earth is more than sixty hours from your local airport." This statement is seen in aviation advertisements in many current magazines. In verification, we occasionally read of unusual battle casualties receiving care in hospitals in this country within a few days of the time of their injury in battle. In the days when these remote regions were separated from this country by several weeks of ocean voyage, there was a definite barrier to the importation of many diseases: during the voyage the disease incubation period would terminate and recognizable clinical symptoms develop. That barrier no longer exists under modern conditions of travel and the only barriers remaining are quarantine regulations and medical alertness. With the present and prospective increase in travel it may be said that any disease formerly confined to foreign shores may appear in this country at any time. What are these strange diseases that sons and husbands, sisters and daughters may acquire and bring back to this country? Which of them will remain an individual problem and which may become a menace to the public health?

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When the problem of tropical diseases is discussed, we have in mind those disease conditions peculiar to the warm climates. Many diseases have been strictly confined to the tropics because of a special link in the chain of epidemiology. Others, so far as their epidemiology is concerned, could flourish very well in temperate climates, but are confined to the tropics by other factors. Still others are included in this category because of increased prevalence under tropical conditions. It has been the custom in the Navy to speak of this group as Tropical and Exotic Diseases. As used here, exotic refers to the unusual. Thus some diseases are included which are seen

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occasionally in this country but are very common under tropical conditions. Bacillary dysentery is one of these. A recent study of 13,500 consecutive hospital admissions for medical causes disclosed that 50 per cent of such cases were tropical diseases, over 4,000 of these being dysentery (Trans. Royal Soc. Trop. Med. & Hyg., February, 1944).

Present day interest is divided between the effect of the present social changes and the effect of particular disease problems upon postwar medicine. My personal interest also involves a consideration of the effect of these factors upon future public health activities, since I expect to return to that work. Under the stimulus of regional military concentrations and with the assistance of federal funds, public health work has shown unprecedented expansion. Under postwar circumstances, curtailment of activities may be encountered and the possible addition of new disease problems is therefore important.

NEW DISEASE PROBLEMS

Every war brings new disease problems to the medical profession. If war takes our troops into tropical countries with their primitive people, then tropical diseases are included in the problem. This occurred in the Spanish-American War when our troops encountered yellow fever in the West Indies and acquired various intestinal infections and infestations in the Philippines. In World War I tropical diseases *per se* did not constitute a problem, but, in the exotic classification typhus fever, trench fever, and hemorrhagic jaundice produced many casualties and deaths. The military forces are vitally interested in preventive medicine, and activities in this field exceed the corresponding public health work of civilian life. Casualties from enemy action or from illness are equally a loss to the military mission. When the illness results from a preventable cause, military public health has failed. In the present war much of our experience to date has been in tropical areas. Tropical diseases are not being avoided as they were some twenty-five years ago. Because of the many years that have elapsed since the last exposure of our forces to them, general interest in tropical diseases has lagged, special interest in tropical medicine and parasitology being maintained by a few hard-working individuals. The only prewar impetus to this subject was derived from the Chicago epidemic of amebiasis. That outbreak, involving over 1,400 people, and resulting in several deaths, disclosed what some of these infections might do under favorable circumstances in this country.

The present war found us not too well prepared as to the number of men familiar with this difficult and complicated problem. During the current activity large numbers of physicians are seeing, for the first time, cases of various tropical diseases. Many of them are treating, also for the first time, some of the less common infections. Unfortunately, the interest of the average physician does not extend beyond the limits of the patient, and the epidemiology of the condition which he treats is lost or very vague to him. At the end of the war, some of these medical men will return to civilian life with excellent postgraduate training. Simultaneously, the problems of tropical medicine have stimulated medical schools to expand their curricula. Students now taking up medicine will have a better knowledge of tropical diseases, even without military experience, than did previous medical graduates. Instruction formerly given in the different medical schools has shown great variation in the emphasis placed on tropical medicine. This is reflected in the medical officers who report to the Naval Medical School for postgraduate instruction. The few who show unusual ability are generally found to be graduates of one of the few schools where tropical medicine has been recognized as an important subject. Recently one of the officers explained that the dean of his school had been an Army Medical Officer. As a result of this war we are developing a healthy respect for the tropical diseases and acquiring an expanded knowledge of them.

Given the ability to diagnose or recognize the tropical disease, immediate medical

interest turns to therapy. In this field, to date, very little new material is available and many of the tropical diseases remain without satisfactory or effective therapy. However, all medical research has been stimulated by the current experience with both the unusual and the ordinary conditions. New therapeutic agents may be developed, just as penicillin has become available, and perhaps the treatment of tropical diseases may also benefit. In any field where therapy is not available, preventive medicine becomes just that much more important. Prevention of tropical diseases will require the attention of the epidemiologist and the entomologist. Knowledge of the etiology and epidemiology should not be considered second in importance to diagnosis and therapy.

INDIVIDUAL DISEASES

The individual diseases which may or may not be introduced into this country may next be considered. In addition, they should be considered as restricted to the individual involved or as a public health menace. At first thought, those persons who have acquired an infection or infestation not transmissible to others do not appear to be of concern to civilian medicine. In large part they will be veterans, their disease will be service connected, and they should be cared for by veterans' facilities. Such facilities are not always close at hand; many of the conditions may not become apparent until after discharge from the service; other conditions will result in chronic or recurrent disability covering a period of years. Because of the bizarre nature of presenting symptoms in many cases, the history of exposure in tropical countries, even for short periods of time, will make it necessary to include various tropical diseases in many differential diagnoses. In all circumstances where the disease possibly may be considered as a menace to others in the immediate environment, the attention of the physician and the public health worker is essential. This calls for a complete understanding of the possibilities involved in each case, and of the etiology and epidemiology of all tropical disease. While no bets should be overlooked, let us not cry "Wolf! Wolf!" without just cause. The west coast of Africa has been called "the white man's graveyard." By transferring the diseases of Africa to this country will similar conditions prevail?

Tropical diseases are confined to a certain environment by reason of certain epidemiological factors. By introducing a new group of people into that environment we may cause disease to spread like wildfire; by introducing the disease to a new area we may cause it to disappear.

The following points are noteworthy:

1. There may be a need for a particular arthropod vector. When this is true we have learned that: (a) In the vector, the etiologic agent may merely increase in numbers, as in yellow fever, a propagative cycle, (b) the etiologic agent may merely pass through a cycle of development, as in filariasis or (c) the etiologic agent may pass through a cycle of development as well as increase in numbers, as in trypanosomiasis.
2. There may be need for a suitable animal host to serve as the reservoir of infection.
3. There may be a need for a human host living in such a manner that the spread of the causative agent is facilitated.
4. There may be a need for a human host living under primitive, unsanitary conditions.
5. There may be a need for a climate suitable for the arthropod vector, the animal reservoir, or the etiologic agent.

ARTHROPOD VECTOR INVOLVED

When an arthropod vector is involved, the climate often must be suitable to support large numbers of them throughout the year in order to maintain the disease. No one will question the favorable influence of tropical climates on insect propagation. Both temperture and humidity may play a part in the cyclic development within the intermediate host. Climate may determine the distribution of the animal reservoir, with many other environmental factors influencing some of them. And finally, the infectious agents may

be favored in their life span outside the host by warmth and moisture.

Various social factors play important parts in the epidemiology of many of these diseases. Under most tropical conditions the human host lives in a primitive manner. These people have tolerated the insect vectors as pests all of their lives. They have been unable or disinclined to improve their conditions. Many of them die from these diseases early in life. It is said that in some areas in Africa, children are given little attention during the first year of life since death is to be expected. Those who survive develop a tolerance for the infection so that it no longer gives them serious trouble, or they recognize the affliction as being similar to that present in past generations and for which nothing apparently can be done. There exists an attitude of resignation on the part of these people; the diseases are secondary to their circumstances and always have been present.

ELEMENTS OF CIVILIZATION

Certain elements of civilization tend to restrict or control disease and they are lacking when standards of living are low, as they are among primitive people. Inadequate food may influence resistance or immunity to disease; immunity is not now considered important in many of the tropical diseases and the diet of some tropical areas may be adequate. Habits of eating are perhaps more important, for example, the consumption of raw fish or the use of seawater as a source of salt. The former is responsible for infection by some of the flukes and the latter has been shown to cause infestation by roundworms. Inadequate clothing, customary in the tropics, is not the result of a low standard of living but does permit of unusual exposure to infection. Inadequate shelter permits exposure to insect vectors, and the crowding which is present favors contact infections. One has only to see how the natives live to realize that many social changes will be necessary before disease can be controlled. An attempt to screen a native dwelling is defeated at the start. Adequate medical care which would control some of these infections is supported neither by the attitude of the people nor by their standard of living. Superstition, ignorance and poverty work together. A missionary told me of a native woman who was charged with disturbing the peace. Witnesses testified that on a certain day each year she struck a certain rock with a special stick and released all of the mosquitoes. She was found guilty.

Where the white man has stepped in with a scientific background and philanthropic resources, as accomplished by Lambert in his crusade against intestinal parasites, medical care can reduce the incidence of many of these diseases. Inadequate fundamental sanitation can be blamed for the continued high incidence of some infections. The disposal of human waste never has been given attention by primitive people, and because of ignorance and superstition the best of WPA privies may remain unused. The deposition of human feces or urine in or near water is necessary in the life cycle of some parasites. When all the factors influencing epidemic disease in the tropics are studied, it is difficult to picture similar conditions arising here.

INSECTS IMPORTANT

Upon studying the group of tropical and exotic diseases, it is immediately apparent that the insects frequently play an important role. On this basis alone certain diseases may be excluded from the problems to be faced by this country. But arthropod vectors not present in a given area must not be introduced accidentally and we must be sure that other arthropods present cannot serve in place of the natural vector. There are many gaps in our knowledge of what tropical diseases might do if introduced into this country. Obviously, those diseases in which the etiologic agent multiplies within the vector may be a greater menace than those in which there is only development, especially so when development may be retarded by an adverse environment. Since all of these disease agents multiply or reproduce within the human host, this factor need not influence a consid-

eration of their comparative menace. A thought must be given to the factor of artificial immunity. Yellow fever is apparently well controlled by vaccine. Typhus fever vaccine may be judged as effective since only two cases in Africa and two in Egypt have been reported in our forces. Cholera and plague may be similarly controlled. However, in military preventive medicine as in public health work, complete reliance is not placed on artificial immunity. In every case other methods of prevention must be employed.

The individual diseases will be considered briefly under the following points:

1. The nature of the etiologic agent.
2. The vector or means of transmission.
3. The cycle within the vector—developmental or propagative.
4. The presence of vectors and natural hosts in this country.
5. The incidence of cases in military personnel.
6. Protective measures available other than those directed against the insect vector.

Since the diseases spread by insects predominate the group, and since the mosquito is most familiar, diseases transmitted by this insect will be considered first.

Table I

Mosquito Transmitted Disease

	Yellow Fever	Dengue Fever	Filariasis
Etiologic Agent	Virus	Virus	Nematode worm
Common Vector	Aedes aegypti	Aedes aegypti Aedes albopictus	Culex quinquefasciatus
Cycle in the Vector	Propagative	Propagative	Developmental
Natural Hosts	Man, monkey, etc.	Only man	Only man
Vector in the U.S.	Yes	Yes	Yes
Military Cases	No	Yes	Yes
Cases Returning	No	Possible	Yes
Protection	Vaccine	——	——

It is believed that general use of the vaccine will prevent the development or the introduction of cases of yellow fever. Preventive measures will continue in the attempt to prevent the introduction of infected mosquitoes. Normally this disease exists in animals of South America and Africa where it is known as "jungle" yellow fever and is transmitted by various jungle arthropods. Man acquires his infection in the jungle, returns to his home and spreads the disease by exposing himself to the mosquito during the early stages of his infection. For dengue fever to be introduced to this country, personnel would have to be returned by air during the short incubation period and exposed to appropriate mosquitos about the time of the clinical attack in order to spread the disease. The rapidly developing epidemic of dengue suggests that early cases are missed and serve as sources of infection; that the virus increases many times in the vector; that the feeding habits of the vector are favorable. Precautions are being taken to avoid the introduction of infected mosquitoes into new areas.

Filariasis represents an error in the interpretation of the epidemiology of disease. It was long felt that infection could result only from long exposure. Now it is known that merely proper exposure is necessary. Living under less favorable conditions in close proximity to native people has produced infections in our troops. It is believed that the returning cases of filariasis will not be a menace in this country. The microfilariae which the mosquito must pick up are not present in these cases. It is believed that, to be infective, such cases must harbor a heavy infection acquired by repeated exposure. Again, we may be wrong.

Table II

Sandfly Transmitted Diseases

	Kala-azar	Oriental Sore	Sandfly Fever
Etiologic Agent	Protozoan	Protozoan	Virus
Sandfly Vector	Phlebotomus	Phlebotomus	Phlebotomus
Cycle in the Vector	Developmental and Propagative		Propagative
Natural Hosts	Dogs and lower animals		Only man
Vector in the U.S.	Related species described; local distribution		
Military Cases	Yes	Probable	Yes
Cases Returning	Yes	Possible	Possible
Protection	——		——

It is very unlikely that these conditions will give more than little concern in this country. The cases of kala-azar should be few and any case of cutaneous leishmaniasis promptly cured when recognized. A condition similar to oriental sore is found in Central and South America. Cases of sandfly fever would return only accidentally because of rapid transit during the short incubation period. The insect vector (to be differen-

tiated from *Culicoides*, also called sandflies) is not prevalent but is locally distributed in Southeastern United States, Texas, and California, and may not be a suitable species.

Table III
Louse Transmitted Diseases

	Typhus Fever	Trench Fever	Relapsing Fever
Etiologic Agent	Rickettsia	Rickettsia	Spirochaete
Vector	Pediculus humanus		
Cycle in the Vector	Propagative	Propagative	Propagative
Natural Hosts	Only man	Only man	Only man
Vectors in the U.S.	Yes	Yes	Yes
Military Cases	Yes	Possible	Possible
Cases Returning	Possible	Possible	Possible
Protection	Vaccine	——	——

The cycle in these diseases is simple—man to louse to man. While our troops may be well cared for and free from lice, they may have contact with others who are not so fortunate. For the introduction of these diseases a case in the infectious stage or infected lice would have to be imported. Except under conditions which permit louse infestation, they will be of no importance in this country. Relapsing fever might be returned during a remission.

Table IV
Tick ,Mite, and Flea Transmitted Diseases

	Relapsing Fever	Scrub Typus	Endemic Typhus	Plague
Etiologic Agent	Spirochaete	Rickettsia	Rickettsia	Bacteria
Common Vector	Ornithodorus	Trombicula	Xenopsylla Cheopis	
Cycle in the Vector	Propagative*	Propagative*	Propagative	Propagative
Natural Hosts	Man, rodents	Marsupials?	Rodents	Rodents
Vector in the U.S.	Yes	Related species	Yes	Yes
Military Cases	Probable	Yes	Probable	Possible
Cases Returning	Possible	Possible	Possible	Possible
Protection	Control of animal reservoir			Vaccine

*Congenital passage of the infectious agent in the vector.

Tick-borne relapsing fever, endemic typhus and plague already exist in this country and their epidemiology and potential menace are understood. While medical officers are alert, it is always possible for an unrecognized case to return during the incubation period of any of these diseases. Scrub typhus has not been widespread and local species of the vector may not be suitable for transmission of the disease. The epidemiology is not completely understood, so far as the natural hosts are concerned.

African sleeping sickness (trypanosomiasis) need not worry us. Chemoprophylaxis is effective for several months and additional field control will reduce the possible cases. It was no doubt brought to this country in slave-trade days but did not survive because the appropriate vector was not present. Chagas'

Table V
Miscellaneous Insect Transmitted Diseases

	African Sleeping Sickness	Chagas' Disease	Other Types of Filariasis
Etiologic Agent	Protozoan	Protozoan	Nematode worms
Insect Vector	Glossina	Reduviids	Chrysops, Simulium
Cycle in the Vector	Developmental	Propagative	Developmental
Natural Hosts	Man, animals	Animals	Only man
Vector in the U.S.	No	Yes	Related species
Military Cases	Possible	Yes	Probable
Returning Cases	Possible	Yes	Probable
Protection	Chemoprophylaxis	——	——

disease has not appeared in the United States in spite of the fact that the infected vector has been found as far north as Utah. Onchocerciasis has been present in Mexico and related species of the vector (black gnat) are very prevalent in some areas of this country. Loiasis, transmitted by the mango fly, similar to the deer fly, is restricted to certain areas of Africa.

Table VI
Miscellaneous Diseases

	Yaws	Leprosy	Hemorrhagic Jaundice
Etiologic Agent	Spirochaete	Bacteria	Leptospira
Means of Spread	Contact, flies	Contact	Contaminated water
Natural Hosts	Only man	Only man	Rodents
Military Cases	Possible	No	Probable
Returning Cases	Possible	No	Possible
Protection	Avoiding exposure		Rodent control

Yaws, for some reason, seem to be confined to the people of the tropics. The relationship of yaws to bejel in the Near East and to syphilis has been a subject of much discussion. Little is known of the behavior of the infection to the white race. If our troops live with natives, cases might result. In contrast to syphilis, both yaws and bejel are diseases of the young. Leprosy and leptospirosis (Weil's disease) are present in this country in sporadic form. The significance of these diseases will be little changed since their epidemiology is so familiar.

Cholera is of concern because of the severity of the disease. Epidemics have been largely confined to the Far East. Bacillary dysentery and amebiasis have been with us constantly and the postwar period will see an

increased incidence due to infection of personnel in the tropics. The persistent carrier state in amebiasis and the infrequent carrier state in bacillary infections will be important

Table VII
Enteric Infections

	Cholera	Dysentery	Amebiasis
Etiologic Agent	Bacteria	Bacteria	Protozoan
Means of Spread	Foods, water, carriers, flies		
Military Cases	Possible	Yes	Yes
Cases Returning	Possible	Probable	Yes
Protection	Vaccine	Sanitation, Detection of carriers	

in the epidemiology in this country. We do not as yet have the answer to the epidemiology in the field. Flies are repeatedly incriminated by their constant presence. The fly in many areas is more prevalent and a greater pest than the mosquito. Yet several epidemics of dysentery have developed before the fly problem became marked and have disappeared in the presence of an increasing fly problem. All known factors in the spread of this disease probably have a part in the production of various epidemics.

Table VIII
Intestinal Roundworms

Etiologic Agent	Hookworm	Strongyloides	Ascaris	Trichocephalus
Means of Spread	Contaminated soil		Contaminated food, water	
Incubation period outside the host	1 week	Variable	10-40 days	6 weeks or more
Military Cases	Yes	Yes	Yes	Yes
Cases Returning	Yes	Yes	Yes	Yes
Protection	Proper disposal of feces Food and water sanitation			

All of these parasitic worms are cosmopolitan in distribution but more common under tropical conditions. Cases now discovered cannot be always properly assigned as to the source of their infection. The potential menace of these conditions will be increased by the increased number of carriers present. As a public health problem, they can all be controlled by a good sanitary inspector if he is given cooperation.

In all of these diseases, treatment is unsatisfactory and there may be a long period between the time of infection and the development of diagnostic symptoms. Because of the complicated life cycle of these parasitic worms, they may be of no public concern. The ova produced by the adult parasite in man must reach water promptly and find a favorable snail host. From the snail they must reach the proper environment to infect man. In the case of schistosoma, the infec-

Table IX
Fluke Infestations

Location in Man	Blood	Lung	Intestine	Liver
Etiologic Agent	Schistosoma	Paragonimus	Fasciolopsis	Clonorchis
Transmission	Water	Crayfish	Water plants	Fish
Military Cases	Probable	Yes	Possible	Possible
Cases Returning	Probable	Yes	Possible	Possible
Protection	Avoid water	Avoid raw or improperly cooked hosts		

tive forms in the water penetrate the skin; the other three are ingested.

Table X

Disease	Returning Cases Expected	Secondary Cases in the U.S.
Filariasis	***	None, IF the cases remain noninfective.
Leishmaniasis	*	None, IF there is no suitable vector.
Trypanosomiasis	*	None, based on past experience.
Borreliosis	*	Only under lousy conditions.
Leptospirosis	**	Very doubtful because of sanitation.
Intestinal Nematodes	****	Where sanitation is inadequate.
Amebiasis	***	Will result from carriers.
Bacillary Dysentery	**	A few will result from the few carriers.
Schistosomiasis	**	Doubtful because of cycle.
Paragonimiasis	*	Doubtful because of cycle.

SUMMARY

In summary, almost any of the tropical and exotic diseases may be encountered in personnel returning to this country. Those for which the natural vector or means of transmission are known to exist must be watched with suspicion. The short incubation period in some and the acute illness resulting in complete recovery or death in others is a protection to the public. Those diseases which give chronic or recurrent symptoms are summarized in table X and show that the sanitarian will continue to be most important.

If a postwar economic depression develops with a decline in the standards of living, many of the tropical and exotic diseases, once introduced, may become a menace to public health. Certain questions are pertinent before a disease can be completely disregarded:

1. In the absence of the normal vector, may not a similar vector be utilized?

2. In the absence of the normal reservoir of infection, may not a new reservoir be established?

3. May not the etiologic agent or the vector become adjusted to a different climate or environment?

4. May not the standards of living and social conditions decline in the postwar period, even in this country?

The President's Page

Many years ago some sage delivered these immortal lines: "Now is the time for all good men to come to the aid of their party." None of my literary friends seem to know the author, their answers varying from Daniel Webster to that of a typewriter salesman, as this sentence has always been one of the first exercises in typewriting. Be that as it may, it's not a bad sentence, and if we substitute the words "medical profession" for "party," it's a whale of a good sentence.

I would ask you to believe that what I say on this page is not partisan politics, but is what I believe to be in the best interest of the health of our nation, and our profession. Will American medicine become socialized? This will be decided early in November, 1944.

There may be many of you who disagree with me. Some of you have already written your disagreement following my page in the October Journal. Shortly after I had sent in that copy, Governor Thomas E. Dewey spoke at Los Angeles, California, on the evening of September 22, 1944, and I quote: "We must help to develop a means for assurance of medical service to those of our citizens who need it, and cannot otherwise obtain it. This is a task that MUST be carried out in cooperation with our medical men. There can be no group better able to advise on medical care than the medical profession. YET, UNHAPPILY, THIS IS THE VERY GROUP WHICH THE NEW DEAL HAS MANAGED TO ALIENATE. Our FREE AND INDEPENDENT medical profession has advanced medical science in America ahead of every other nation in the world. ITS FREEDOM—ITS VERY FREEDOM—is what has made it great. It should be encouraged, not discouraged. Let us enlist the leadership and aid of the doctors of America in organizing our private and public hospitals as well as our other services into a fully effective system to protect the health of all our people."

To me this statement is clear and concise and should be understood by every man in the practice of medicine. We have felt that the "Wagner Bill," a pet project of the New Deal, was dead, but I for one feel that it, or its equivalent, is a "sleeper" and will be tossed into a faovrable Congress at the earliest opportunity. Some of you may favor the federal control of medicine. If you do, you are not to be condemned, and there is no question how you should vote. But the "medico" who gets me is the one who will "stand up on his hind legs and holler" against Socialized Medicine, and then sit down and with his front paws write an "X" on the wrong side of the ledger. One of my political friends said to me a short time ago, "Don't let me hear any of you doctors crying about Socialized Medicine next year unless you've made an effort to check it at its source."

Again, I say, let your conscience be your guide, but remember the date—November 7, 1944. American Medicine is surely at the cross-roads!

President.

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MIRABILE DICTU!

The November issue of The American Magazine carries a very intriguing article from the pen of Mr. Harry Hopkins the title of which is "Your Job After the War." The whole presentation is essentially rightist and rather amazes us coming from one whom we have been accustomed to looking upon as leftist in tendency and in fact the very quintessence of the New Deal. Much of the philosophy of the article smacks materially of that enunciated by Governor Dewey in some of his recent campaign blasts. To us the most astounding feature of the article is the statement with reference to medical care. Certainly we have been led to believe that the worshippers in the Sanctum Sanctorum of the New Deal (and we have always felt that Mr. Hopkins occupied a pew in the amen corner of that auditorium) held socialization of the medical profession as a sort of fetish. But listen to this: "Adequate medical care must be available at all income levels. To work, men must be well. Sickness is a job-loser. The health of the American people can be improved through health insurance and increased public services. *We do not need socialized medicine to do the job.*" (Italics ours.)

Of course a national election, and apparently a close one, is looming. But perhaps we have been in error in assuming that Mr. Hopkins has in the past favored socialized medicine. Or perhaps the opinion he expresses is the result of his close contact with medicine and the medical profession in the last several years, for certainly, if our information is correct, he owes much to the skillful hands of one of the most distinguished members of the medical profession. At any rate, Mr. Hopkins' frank statement gives us much pleasure, and we would welcome like frank expressions from sundry other high priests of the New Deal now sojourning in the National Capitol.

CENTRAL STATE MERGER

After functioning for nearly a half century as an active medical organization, the Lewis County Medical Society has voted unanimously to consolidate with the Central West Virginia Society. The merger was completed on October 20, with the unanimous approval of the members of the last named society.

The Lewis-Upshur Medical Society was organized in 1899 principally through the efforts of Dr. T. M. Hood, of Clarksburg, who died recently in that city at the age of 91 years. That same year, the State Medical Association held its annual convention at Weston, and the late Dr. Charles S. Hoffman, of Keyser, was elected president. Subsequently, in 1915, the doctors of Upshur County withdrew from the Lewis County Society and became members of the Central West Virginia Society, then composed of doctors residing in Nicholas, Braxton and Webster counties.

Three members of the Lewis County Society who were charter members at the time of the organization of the Lewis-Upshur society are still in practice at Weston and are members of the Lewis County Society. These members, Drs. George Snyder, W. P.

King and E. T. W. Hall, are now honorary life members of the local society and the State Medical Association. They have always been active in the work of their organization.

The consolidation of these two medical societies in Central West Virginia will mean an active roll of well over 50 doctors. The Lewis County Society includes doctors residing in Gilmer county and members of the enlarged Central West Virginia Society residing in six adjoining counties can conveniently meet at the county seat in any of these communities.

It has been increasingly difficult during the past several months for societies with a small membership to obtain speakers for their meetings. This consolidation will result in much benefit to the memberes, and the Central West Virginia society, strengthened by the addition of the membership of the Lewis County Medical Society will continue as one of the strongest and most active component societies of the State Medical Association.

OUR PSYCHIATRIC PROBLEMS

When we consider that approximately one discharge in three from the American Army thus far in World War II has been for neuropsychiatric disabilities, the magnitude of this problem after full demobilization begins to dawn upon us. Realizing that West Virginia physicians should be prepared to meet this need, President Robert J. Reed, Jr., with the consent of the Council of the State Medical Association, recently mailed out a questionnaire covering the problem to physicians in civilian practice in the state, approximately one-fourth of whom replied promptly. The great majority of those who returned questionnaires desire some form of postgraduate instruction in neuropsychiatry, especially as it relates to general medicine. Seminars in the local societies and a symposium in the West Virignia Medical Journal were frequently suggested. At the next meeting of the Council plans will be discussed for furnishing such postgraduate instruction.

LOCAL SOCIETIES RESPOND

The response of component medical societies to the request of the cancer committee of the West Virginia State Medical Association to devote one meeting to the discussion of cancer control is most heartening.

Already, Dr. Paul R. Gerhardt, director of the division of cancer control of the state health department has appeared before meetings held by probably a dozen societies. Several members of the Association's cancer committee have also taken an active part in these meetings. Programs have been arranged by other societies which will be presented at meetings to be held during the winter.

The division of cancer control reports that 101 cases of cancer were under care as of October 20, and fifteen other cases were pending as of that date.

More and more doctors are realizing the importance of the work that can be done in connection with our cancer program in West Virginia, and good results may certainly be expected from the work that is being done and will be done by Dr. Gerhardt in cooperation with the members of the cancer committee and individual doctors in all parts of the state.

MONONGALIA HEALTH CENTER

The Monongalia County Health Center, built on the grounds of the Monongalia County Hospital, just outside the city limits of Morgantown, was formally dedicated on October 16, 1944. This is the first building to be constructed in any county in West Virginia for the sole purpose of housing the various health units of a community. The building, which is located directly across the street from the hospital, will be under the supervision of Major Ward Oliver, USPHS, County Health Officer. Dr. J. E. Offner, State Health Commissioner, very fittingly served as chairman of the dedicatory program, and the principal address was delivered by Mr. Walter L. Hart, editor of the Morgantown New Dominion.

The new health center is equipped adequately to provide for the needs of the health program in Monongalia county, and was built as a result of the combined efforts of the county court, public health officers, doctors and civic minded citizens of that county.

We commend the efforts of these forward-looking people in Monongalia County and suggest that other communities may well consider the establishment of similar centers in their home communities.

MAIL FROM HOME

The most important hour in the biggest day of the week or month in the life of the doctor in military service is the arrival of mail from home. Our members with the armed forces write us that those back home will never know how much a letter means to a doctor away from home, be he in a camp in this country or far away in some overseas battle zone.

More than 50 per cent of the members of the State Medical Association now in the military service are stationed overseas. Week by week others are being transferred to foreign service. Some are constantly on the move, especially those with the invasion forces on the Western Front and with troops operating in the Southwest Pacific. While prompt delivery of mail is impossible in such cases, letters, papers and packages eventually catch up with the addressee.

Many of our doctors here at home are writing regularly to their friends in the service. With very few exceptions correct military addresses for the members of the Association are on file in the headquarters offices at Charleston. These addresses cannot be printed in the Journal, but will be furnished promptly upon request by mail.

Thanksgiving is just a few weeks ahead, and then Christmas. Gladden the heart of someone or more of the doctors who cannot be home for the holidays by writing a newsy letter about things in which you and he are mutually interested. To do so now would mean that your letter will most likely be delivered by Thanksgiving. Mark your calendar so you won't forget to write another letter for Christmas. Literally, the ends of the earth are just a few days away from West Virginia by air mail.

HONOR WELL DESERVED

Captain Alphonse McMahon, (MC), USNR, whose paper, "Medicine in the South Pacific," is printed in this issue of The Journal, was recently honored by the Mississippi Valley Medical Society as its distinguished award recipient for 1944. The many friends of Captain McMahon in West Virginia will remember him as one of the prominent speakers on the program at the annual meeting in Wheeling last May.

According to the *Journal of the American Medical Association*, the citation accompanying the award, which consisted of a gold medal and certificate, read in part as follows:

"To Captain Alphonse McMahon of St. Louis, Medical Corps, U. S. Navy, for his long service as a teacher of clinical medicine at St. Louis University Medical School; for his continuous interest in postgraduate medical education, in recognition of which he was elected Vice President of the American Medical Association and President of the St. Louis Medical Society a few years ago, and for his fine example as a citizen of the United States by leaving a lucrative private practice promptly on declaration of World War II and entering the U. S. Navy although over the draft age. Here he spent eighteen months in the South Pacific in the establishment of one of the first hospitals to receive combat injured from the battles of the Coral Seas and Guadalcanal, in recognition of which he has been cited by Admiral William F. Halsey as a naval officer who has 'reflected great credit on himself by his outstanding professional ability and keen judgment, particularly in the management of war wounds and in the treatment of tropical diseases. His long experience as a teacher of medicine and his effective leadership in the instruction of young medical officers contributed materially to the success of the Navy's operations.' "

We join with the friends of Captain McMahon all over the country in extending to him hearty congratulations.

General News

OVER 300 WEST VIRGINIA DOCTORS REPLY TO PSYCHIATRIC QUESTIONNAIRE

Over 90 per cent of the more than 350 West Virginia doctors who have expressed themselves on the subject feel that further knowledge of psychiatry would be of help to them in their practice.

Replies received as the result of a questionnaire mailed late in August to the members of the State Medical Association by Dr. Robert J. Reed, Jr., of Wheeling, president, also indicate that at least 80 per cent of the doctors are desirous of knowing more about emotional illness.

In his letter to the members of the Association, Doctor Reed stated that many men rejected for service in the armed forces and a large percentage of the million men discharged from military service present psychiatric problems to a greater or lesser degree. It was for the purpose of determining the extent of the interest of the doctors of West Virginia in this problem that the questionnaire was prepared and mailed.

Doctors were requested to report to Dr. R. J. Wilkinson, Chairman of the Council, the extent of their practice concerned with the treatment of patients with functional or nervous disorders, the frequency with which they have been seeking special psychiatric aid for such patients, and the availability of trained psychiatric help.

Less than 15 per cent of the doctors replying to the questionnaire state that they have had any training or developed any working concept in psychiatry and most all report that there is a general lack of psychiatric assistance in the state. Over 90 per cent of the doctors state that they are interested in seminars on psychiatry to be held evenings at meetings of component medical societies, and 50 per cent of the group of those interested expressed themselves as being willing to pay a nominal attendance fee.

Asked if they would be interested in a symposium on psychiatry to be presented in the West Virginia Medical Journal over 70 per cent answered in the affirmative.

In making a plea for the presentation of psychiatry in simple terminology doctors ask that it be related to general medicine. For the most part, aid is desired specifically for the handling of psychoneuroses, sub-clinical personality problems and psychosomatic disturbances.

A summary of replies received to the questionnaire will be presented to the Council at the November meeting for the purpose of determining what part, if any, the State Medical Association will play in providing a general program on psychiatric education for the doctors practicing in this state.

ALL TECHNICAL EXHIBIT SPACE SOLD

Preparations already completed for the 78th annual meeting of the West Virginia State Medical Association, which will be held May 14-15, 1945, at Clarksburg, augur well for the success of this yearly convention of West Virginia doctors. The Scientific Work committee, in cooperation with the heads of the various sections and special societies, has the program well on its way. Doctors of national and international reputation are on the program. Exhibitors have shown an unusual interest in making reservation for space. All commercial space available was sold within three weeks after the floor plan was distributed to prospective exhibitors.

Dr. Hu C. Myers, of Philippi, who has served as chairman of the Committee on Scientific Exhibit for the past four years, has again taken over this job and is preparing to present the usual display of interesting scientific projects.

Hotel accommodations are still available, and doctors are urged to make their reservations immediately.

COUNCIL AND COMMITTEES TO MEET

The regular fall meeting of the Council will be held at the Daniel Boone Hotel, Charleston, Thursday, November 9, at six o'clock. The session will be preceded by meetings of several Association committees. The Scientific Work (program) Committee will meet at 10 A. M., and a joint meeting of the Legislative, Medical Education and Fact Finding and Planning committees is scheduled for noon.

Several matters of importance will be considered at these meetings, principally the legislative program of the Association for 1945.

All officers and councillors-elect have been invited to attend the meeting of the Council, and members of that body who reach Charleston by noon have been requested to sit in at the meetings scheduled for the afternoon.

LICENSED BY RECIPROCITY

As a result of the examination conducted by the Public Health Council at Charleston, October 2-4, 1944, the following doctors have been licensed by reciprocity to practice medicine in West Virginia: Florian Baughan, Hemphill; Richard Brinsley Sheridan, Parkersburg; Joseph Edwin Ricketts, Dillonville, Ohio; Bill Ballard, Beckley; James Aaron Pickering, Sofia; Thelma Viola Owen, Huntington; Woodrow Wilson Mills, Huntington; Rose Hamlett McClanahan, Charleston; Ballard Repass Gibson, Omar; Sidney Irwin Franklin, Welch; John Letcher Chestnut, Marlinton; Elizabeth Grant Bess Cannon, Keyser; and Catherine Harmon Brewer, War.

TUMOR CLINIC AT MORGANTOWN

A tumor clinic has been organized at Morgantown under the sponsorship of the Monongalia County Medical Society. Members of the Society will serve at the clinic, which will be held at least once a month, and patients will be advised to return to their own doctors with recommendations for treatment if necessary. The usual treatment recommended will be surgery, radium and deep x-ray therapy. The first clinic was held at Morgantown, Friday, October 27.

WEST VIRGINIANS AT AHA MEETING

At the 43rd annual convention of the American Hospital Association held at Cleveland, October 2-6, Dr. Donald C. Smelzer, of Philadelphia, was elected president to succeed Frank J. Walter, of Denver, Colorado.

The following West Virginians were present at the meeting: Drs. Hu C. Myers, Philippi; W. O. McMillan, Charleston; and A. F. Lawson, Weston. Hospital representatives also attended the meeting as follows: R. J. Wilkinson, Jr., Wilkinson Clinic, Huntington; Charles E. Vadakin, Fairmont General Hospital; J. Stanley Turk, Ohio Valley General Hospital, Wheeling; Charles C. Warner, Mountain State Memorial Hospital, Charleston; and B. B. Dickson, Stevens Clinic Hospital, Welch.

SCIENTIFIC EXHIBIT CHAIRMAN NAMED

Dr. Hu C. Myers, of Philippi, has been named by Dr. Thomas L. Harris, president elect of the State Medical Association as chairman of the committee on scientific exhibit for 1945. Doctor Myers has served in this capacity for the past four years.

WEST VIRGINIA GRADUATES AT MCV

Commencement exercises for the 107th session of the Medical College of Virginia, at Richmond, were held at the Mosque Theatre in that city September 23, 1944. Degrees in medicine were granted to the following graduates from West Virginia:

Earl McKenzie Bane, Charles Town; Joel Foster Carr, Princeton; Otis Wilson Corder, Jane Lew, Robert Russell Dennison, Huntington; Walter Augustus Eskridge, Marlinton; James Allen Farley, Huntington; Claude Albee Frazier, Winona; Charles Dotson Houck, Lewisburg; Margueritte Elizabeth Kersey, Bluefield; William Ward Kersey, Jr., Bluefield; Wallace Byron Lilly, Beckley; Hal Waugh Smith, Montgomery; James Tidler, Clarksburg; Evelyn Clark Wade, Huntington; and Walter Richmond Wilkinson, Huntington.

Diplomas in nursing were granted to the following graduates from West Virginia:

Dorothy Brent Berk, Worth; Loretta Pauline Jessee, Bartley; Margaret Ann Roberts, Bramwell; Frances Virginia Shewey Charleston; and Geraldine Terrell, Ronceverte.

RELOCATIONS

Dr. F. P. Eves, who has been on the staff at Charleston General Hospital, is now located at Ward.

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Dr. J. K. Pickens, of Iaeger, has moved to Layland.

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Dr. R. W. Quaintance, of Lundale, has located at Slate Mills, Virginia.

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Dr. J. S. Maxwell, of Fairmont, has been named college physician at Wheaton College, Wheaton, Illinois, and has moved to his new location.

APPROVED CANCER CLINICS

The following cancer clinics in West Virginia are on the approved list of the American College of Surgeons: Bluefield Sanitarium, Bluefield; Mountain State Memorial Hospital, Charleston; St. Mary's Hospital, Huntington; Laird Memorial Hospital, Montgomery; and Camden-Clark Memorial Hospital, Parkersburg. The cancer diagnosis clinic at St. Mary's Hospital, Clarksburg, is on the approved list of institutions conducting cancer diagnostic clinics.

WITH DOCTORS IN THE SERVICE

The following interesting letter from Lt. Col. S. S. Hall, of Clarksburg, dated September 12, was received September 27:

New Guinea

Dear Charles:

My July copy of the West Virginia Medical Journal recently arrived. I read it with keen interest and am glad that its high standards are being maintained even under present conditions. The section dealing with those of us in the armed forces is read very carefully. It is the only contact many of us have with each other.

This is real jungle country. The terraine is low falling hills backed up by high mountains and still higher peaks, all covered with virgin jungle perpetually green. The forests cover tens of thousands of square miles. The usual jungle undergrowth is all but impenetrable, but is filled with beautiful trees 80-140 feet tall, 36-48 inches in diameter, and 60-120 feet to the first branches, and straight as a string. However, I'm not interested in a saw mill! Mone of the trees are of our West Virginia variety I have learned to recognize some, the widely distributed cocoanut palm, wild rubber tree, and the kapok trees.

Lt. Col. S. S. Hall

Bananas, papayas and mangoes are indigenous here and we get some extra vitamins and fresh fruit from a natural immediate source. We had quite a long "staying period" at my former location, so I collected butterflies and moths which I've sent to my family. I had at least sixty different kinds, none of which I had ever seen in West Virginia. I seriously doubt if some I sent have ever been named.

I've done the usual American soldier's trick, collected all kinds of souvenirs which I've also sent home. I am sure they will find their way to the attic eventually but they will probably provide some interesting periods for my youngsters.

We are building rapidly and will have opened officially before this letter reaches you. We are all anxious to get to work. The hospital problem here is a real one. We have to run the Japs out, then the mosquitoes. As an added touch, we clean out a virgin jungle. After a lot of hard manual labor, we are ready to construct the physical plant. It is rough going. In Europe, permanent construction is often waiting, ready for occupancy.

I'm in excellent health, weigh 175, have a perfect 34 waist line, and have a deep sun tan with yellow orange tint (from atabrine). I hope my luck holds.

Regards to all.

Sobisca.

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Major Seigel W. Parks, of Fairmont, writes from France that he has been seeing some historic country. "The hedgerows are a very familiar sight by now," he says, "and I have seen many of the towns where terrific fighting took place. It is impossible to imagine the extent of the damage until you have seen it with your own eyes and then thought about it for several days." Major Parks says that Paris is still "Gay Paree", and that with the exception of the large numbers of military personnel one sees on the streets, it is hard to realize that the rest of the country has gone through four years of war. He sends his best wishes to the doctors of West Virginia.

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The day to day routine of field life is not unpleasant, according to Major Karl E. Weier, of Bluefield, who is with the marines somewhere in the Southwest Pacific. "The good fellowship of solid and deep friendship abounds," he says, "and the only concern that most of us have is how soon before we'll be home again, and how things will be when we get there. When you see Drs. R. O. Rogers, Harry G. Steele and Frank Holroyd, be sure to give them my best regards."

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Capt. J. A. Campbell, of Beckley, is assigned to the Army Air Field at Venice, Florida.

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In a note attached to a printed request for a ballot to be used in the November election, Capt. James L. Hager, of Charleston, who is in the southwest Pacific, says, "I am getting closer to the Phil-

ippines. Hurrah!" Capt. Hager has seen service both in Australia and New Guinea.

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Lt. Rank O. Dawson, of Charleston, who is assigned to the Navy Department Dispensary, at Washington, was assigned to sea duty on a battleship for over two years, seeing service in the North and South Atlantic, Mediterranean, and Indian Ocean. During that time he visited Canada, Iceland, the British Islands, North Africa, South Africa, South America, and India, and with his unit he participated in the Sicilian campaign.

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Lt. Ralph Hogshead, Jr., son of the late Dr. Ralph Hogshead, of Mammoth, has completed his internship at the Lankenau Hospital, Philadelphia, and has reported for active duty with the army at Carlisle Barracks, Pennsylvania. Sometime in November he will be assigned to Baxter General Hospital at Spokane, Washington. A younger son, George, was graduated from Temple University School of Medicine, September 14, and is interning at Philadelphia Hospital, Philadelphia.

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Capt. Thomas L. Woodford, of Belington, is assigned to General Patton's 3rd army, driving on to Berlin.

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Lieut. Comdr. William A. Thornhill (MC), USNR, of Charleston, was called home recently on account of the death of his mother, Mrs. W. A. Thornhill, Sr. Commander Thornhill, who has been stationed at the U. S. Naval Hospital at Newport, R. I., has been transferred to the National Naval Medical Center at Bethesda, Maryland.

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Lieut. Comdr. L. E. Kroger, of Parkersburg, is beginning his third year as head of the Industrial Hygiene Department at the U. S. Navy Yard at Portsmouth, N. H. He is the oldest physician in point of service at that station. He writes that he expects his orders each month for sea duty on a foreign assignment. However, such orders have not yet come through, but over 100 physicians have received their indoctrination and have been sent overseas. "We sometimes get disgusted fighting the battle of Portsmouth, N. H., he writes, "but I have been told that someone must stay behind and do it. Perhaps my turn will come later on."

Capt. Robert A. McLane, Jr., of Masontown, who has been with the SAACC at San Antonio, is now assigned to Goodfellow Field at San Angelo, Texas. He was recently promoted from Lieutenant to his present grade.

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Lt. Karl E. Weier (MC), USNR, of Bluefield, writes from somewhere in the Pacific that his work consists chiefly of treating fungus infections, neuroses, and all sorts of traumatic injuries. "Shells, butterflies, and native customs," he says, "broaden one's interest, with reading, writing letters, and 'shooting the breeze' providing the major pastimes."

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Capt. Robert W. Bess, of Keyser, who has been in Guadalcanal for several months, has returned to the states and is now stationed temporarily at Camp Dietrich, Frederick, Maryland.

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Capt. A. J. Given, of Rensford, is assigned to an Army Hospital Ship operating somewhere in the European Theater.

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Lieut. W. D. McClung (MC) USNR, of Richwood, who has been stationed at the Naval Air Center at Hampton Roads, Virginia, has been assigned to the U. S. Naval Air Force Base at Dinner Key, Miami, Florida.

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Capt. Francis L. Coffey, of Huntington, who has been stationed at Valley Forge General Hospital at Phoenixville, Pennsylvania, is now assigned to the Deshon General Hospital at Butler in that state. He was recently promoted to his present rank.

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Lieut. Charles M. Polan, of Huntington, who has been serving as assistant chief of EENT at the Station Hospital at Camp Luna, Las Vegas, N. M., is now assigned to the 1375th AAF Bn. at Manchester, N. H.

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Capt. Edward Press, of Charleston, has been transferred from the AAF Station Hospital at Homestead, Florida, to the Chemical Warfare School at Edgewood Arsenal, Maryland.

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In the following letter received from Captain Richard N. O'Dell, of Belle, now with Patton's army on the trek toward Berlin, the need for and value of close personal medical supervision of our fighter groups is clearly shown:

France, 26 September, 1944

My dear Mr. Lively:

I appreciate very much the receipt of the ballot request. Things have been moving so fast I had neglected to send for one.

With eight months service in England and over three months in France news from home is particularly welcome. Receipt of the Medical Journal is always an event as it brings such news, as well as articles of current interest in medicine, which are much needed where we have little actual medical contact.

I have been with the Pioneer Mustang Group of the 9th Air Force as a Squadron Flight Surgeon for one year, ten months of which has been in combat. I am proud to be a member of an organization which has introduced long range fighter escort for bombers, introduced the P51 Mustang as a dive-bomber and for strafing, and destroyed almost 600 German aircraft in less than ten months.

The problems of Aviation Medicine have been well met by the medical profession and the combat pilots are very grateful. They have been able to fly freely at all altitudes, in all kinds of weather, under conditions of terrific nervous strain because far seeing members of the profession had previously made extensive studies of the physical and mental reactions associated with all types of flying. With this and additional up-to-date information pouring in from all combat theatres we are able to watch our pilots and salvage them before they have reached the limit of their endurance. Because they know the watchful eye of some medic is on them to protect them from physical or combat exhaustion they are able to devote more fully their abilities to actual combat.

I have had the good fortune to serve under and with some of the outstanding fighter pilots of the war. Nothing would be gained by elaborating on their exploits for they have received national acclaim in papers all over the United States. It is sufficient to say that association with such men who are literally giving their lives for their country moves one to give all that is possible in the way of medical service.

In the air force we have a little more freedom than other members of the armed forces. This is probably due to the fact that every pilot is an individual fighting machine and functions more or less independently. Even though moving from one air field to another and living under field conditions we manage to have some of the until now little appreciated comforts of life. We have well constructed break-down showers, portable sectioned mess hall and kitchen, portable latrines, pressure gasoline heating units capable of heating 100 gallons of water in a few minutes, and many other accepted comforts of civilization, all conceived and executed by the intelligent initiative of enlisted men and officers. Sometimes it is quite a problem to transport all this excess baggage but at the last minute by a little juggling and smuggling it shows up at the new post.

Shortly before coming to France I heard from Capt. R. L. Calvert, M. C. (formerly of Chelyan and Huntington). He was assigned to a hospital train in England and doing a good job.

Sincerely yours,

Richard N. O'Dell

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Lieut. F. Eugene Amick, MC, formerly of Richwood, visited his mother at Charleston late in October. He was on sick leave on account of a slight accident which occurred at Fort Benning, Georgia, where he is attending Parachute School. Lieut. Amick was formerly a resident at Charleston General Hospital.

County Society News

CABELL COUNTY

Dr Bruce K. Wiseman, Professor of Medicine at Ohio State University School of Medicine, Columbus, was the guest speaker at the regular monthly meeting of the Cabell County Medical Society held at the Frederick Hotel, Huntington, October 12, 1944. Doctor Wiseman, widely recognized as one of the leading hematologists in this country, spoke on the subject of "Diagnosis and Treatment of Thrombocytopenic Purpura."

At the business meeting following the scientific session, officers, delegates and members of the board of censors for the ensuing year were elected as follows: President, J. H. Steenbergen; vice president, J. F. Barker; secretary, C. A. Hoffman; and treasurer, I. R. Harwood (reelected). Board of Censors, C. G. Willis, C. B. Wright, and J. F. Berker. Delegates, O. B. Biern and F. C. Hodges. Alternates, W. J. Parsons, R. M. Wylie, and Dorsey Ketchum.

COLE D. GENGE, M.D., *Secretary.*

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CENTRAL WEST VIRGINIA

At the fall dinner meeting of the Central West Virginia Medical Society, held at the Webster Springs Hotel, Webster Springs, October 20, at 6:30 P.M., Dr. Edward F. Reaser, of Huntington, was the guest speaker. He presented a most interesting paper on "The Emotional Factors in Illness." Drs. Cofer, Van Tromp and Walker discussed the paper.

Mr. Charles Lively, Executive Secretary of the State Medical Association, was present and at a roundtable session discussed the proposed legislative program for 1945.

The meeting was largely attended by members and their wives and several guests.

At the business session following the dinner, Dr. E. A. Trinkle, President of the Lewis County Medical Society, was presented and stated that the members of his society had voted unanimously to ask that a merger be effected with the Central West Virginia Medical Society, the latter name to be retained as the official name of the organization. The members present voted unanimously in favor of the merger, and it was agreed that the

Lewis County charter is to be surrendered to the House of Delegates at the annual meeting at Clarksburg in May, 1945. The next meeting of the Society is to be held in March, 1945, and the members of the Lewis County society will attend.

The following officers were elected for 1945: President, Dr. E. H. Hunter, Webster Springs; and, vice president, Dr. B. L. Page, Buckhannon. Dr. J. M. Cofer, of Bergoo, was unanimously elected to succeed himself as secretary-treasurer. It was announced that delegates and alternates to the House of Delegates would be elected at the next meeting of the society.

Following his induction into office, the new president, Dr. Hunter named the following as members of the legislative committee: Drs. A. E. Long, Weston; Worth B. Forman, Buckhannon; E. L. Fisher, Gassaway; Eugene S. Brown, Summersville; and George D. Hill, Camden-on-Gauley.

Dr. T. H. Millman, formerly of Earling, now located at Richwood, was accepted as a new member by transfer from the Logan County Society.

J. M. COFER, M.D., *Secretary.*

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KANAWHA MEDICAL SOCIETY

Dr. J. Bankhead Banks and Dr. W. G. J. Putschar, of Charleston, were the guest speakers at the regular monthly meeting of the Kanawha Medical Society, held at the Daniel Boone Hotel, Charleston, October 10, at 8 P. M.

Dr. Banks spoke on the subject of "Graded Ligation and Retrograde Injection of Varicose Veins." The paper was illustrated by moving pictures and was discussed by Drs. T. H. Blake, R. A. Ireland, and others.

Dr. Putschar's subject was "Pathology of the Thyroid." The paper was discussed by Drs. Buford, Dent, Stewart, Squire, and Elkin.

At the business session which was held following the meeting, Dr. C. M. Fleshman, of Clendenin, was reinstated as a member of the Society.

Dr. Henry Baum, chairman of the committee on Maternal and Infant Deaths, submitted a report in which he outlined the best methods by which the subject could be studied and discussed. Action on the report was postponed.

A resolution was presented by Dr. Duke A. Dent, urging local health officials to adopt a system similar to that used by the licensing board for barbers and beauticians whereby a serologic report from a licensed laboratory must accompany each record of examination and be filed as a part of the record. The resolution was unanimously adopted and the secretary was directed to forward a copy to the city health officer, Dr. J. E. Robins, Jr.

The president appointed the following as members of the nominating committee to name officers for 1945: Drs. Dent, Squire, and Point. The committee is to submit a report at the next meeting of the Society.

Following the business meeting, Dr. H. M. Beddow entertained the members by showing several reels of colored moving pictures made recently in Alaska and the Aleutians.

W. P. ELKIN, M. D., *Secretary.*

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MERCER COUNTY

A joint meeting of the Mercer County Medical Society and Auxiliary, followed by a picnic and square dance, was held at Glenwood Park near Bluefield, September 22.

Dr. Harry G. Steele, of Bluefield, was unanimously elected president of the Society to succeed Dr. Frank M. Huff, who is locating at Oklahoma City, Oklahoma. An interesting paper on "Renal Hypoplasia with Hydroureter and Primary Amenorrhea," with report of a case, was presented by Drs. William B. Boger and Frank M. Huff. The paper was discussed by Drs. J. I. Markell, H. G. Steele, R. O. Rogers, J. R. Shanklin, and A. C. Van Reenan.

FRANK J. HOLROYD, M.D., *Secretary.*

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POTOMAC VALLEY

The regular monthly meeting of the Potomac Valley Medical Society was held at Petersburg, September 27, 1944. An interesting paper on penicillin was presented by Dr. Thomas Bess, of Keyser.

Dr. Paul R. Gerhardt, Director of the Division of Cancer Control of the State Health Department, delivered an address on Cancer Control at the regular monthly dinner meeting of the Potomac Valley Medical Society, held at the Potomac Valley Hospital, Keyser, October 18. Mr. Charles Lively, Executive Secretary of the State Medical Association, was present and discussed the legislative program of the Association which will be considered by the Council and various committees at a meeting in Charleston in November.

E. A. COURRIER, M. D., *Secretary.*

PSYCHIATRIC REHABILITATION

It would be of little use to rehabilitate men to the point where they are perfectly normal if the public will not accept them at face value. To bring about this acceptance will require an education of the public. It should be recognized that all of us, without exception can become psychoneurotic provided the stage is properly set and the predisposing and existing causes are properly juxtaposed.

One of the great problems, therefore, will be the preparation of the niche in which the veteran is to fit upon his return. The education of the public, and particularly the employer in this regard, is a problem which requires immediate attention. People are well-meaning and are anxious to help. They will respond to calls for help in the rehabilitation of men even as they have responded to other calls.—*Com. Francis J. Braceland.*

SOUTHERN CHAPTER OF ACCP TO MEET

The annual meeting of the Southern Chapter of the American College of Chest Physicians will be held conjointly with the annual meeting of the Southern Medical Association at St. Louis, November 13-16, 1944, with headquarters at the DeSoto Hotel. Dr. Walter E. Vest, of Huntington, has been named toastmaster for the President's dinner, Monday evening, November 13. The guest speaker will be Dr. Herman E. Hilleboe, of Washington, D. C., Medical Director Chief, Tuberculosis Control Division, U. S. Public Health Service.

The first scientific section will be held at the St. Louis Municipal Auditorium, November 13, with Dr. Paul H. Ringer, of Asheville, North Carolina, president of the southern chapter, presiding. The second session will be held at 9:00 A. M. the following day, with Dr. Herbert L. Mantz, of Kansas City, Missouri, presiding. The meeting will end with an X-ray conference at the DeSoto Hotel at 2:00 P. M.

GRADUATES IN AVIATION MEDICINE

Lieutenant James R. Goodson, of Davy, has graduated from the School of Aviation Medicine, at Randolph Field, Texas, according to the *Journal of the American Medical Association.* Graduation exercises for the class of which he was a member were held at Randolph Field late in July.

Obituaries

THOMAS MILTON HOOD, M. D.

Dr. Thomas Milton Hood, of Clarksburg, died at his home in that city September 27, 1944, at the age of 91. Besides being the oldest living alumnus of West Virginia University and Jefferson Medical College, he held the distinction of being the oldest living member of the State Medical Association, and was the oldest past president at the time of his death.

Until a few years ago, Dr. Hood was a familiar figure at all annual medical meetings, in company with his life-long friend, Dr. Charles Oliver Henry, of Fairmont, who died in 1942 at the age of 84 years. Until failing eyesight caused his retirement from practice a few years ago, Dr. Hood was active in all the affairs of the Association. He never failed to attend and take part in the proceedings of the Association's House of Delegates.

Thomas Milton Hood, M. D.

Doctor Hood was born April 20, 1853, near Lowesville, Monongalia County, son of John S. and Mary M. (Smyth) Hood. He attended public schools in his home community and graduated from West Virginia University in 1877 with the degree of A. B., being one of a class of nine. After studying medicine in the offices of local physicians, he spent a year at the Maryland School of Medicine, in Baltimore, and then entered Jefferson Medical College, Philadelphia, from which he graduated in 1880, with the degree of M. D.

He began the practice of medicine at Lumberport and Shinnston, and in 1882 was married to Dora W. Foreman. That same year he moved to Cassville.

After completing postgraduate work at the Polyclinic Hospital, New York, Doctor Hood in 1887 accepted appointment as assistant superintendent at the Weston State Hospital (mental). He held this position until 1895, when he resigned to take additional postgraduate work in New York. Late that year, he opened offices for the general practice of medicine in Weston with the late Dr. Robert A. Haynes. He moved to Clarksburg in 1896 where he practiced until his retirement.

Doctor Hood was twice elected president of the Harrison County Society, and in 1905 served as President of the West Virginia State Medical Association, when the annual meeting was held at Wheeling.

Besides his widow, he is survived by three children, Edgar F. Hood, and Agnes Hood Gronemeyer, of Clarksburg, and Dr. Robert C. Hood, of Arlington, Virginia. One brother, Smyth Hood, of Clarksburg, also survives. Funeral services were conducted at Clarksburg, September 29.

ELI WHITNEY ROSE, M. D.

Eli Whitney Rose, M. D., 84, of Hundred, died of a heart attack September 29, 1944, on the Hundred-New Martinsville Highway, while placing chains on his car, enroute from his home to answer a call.

Dr. Rose, who had practiced medicine in West Virginia and Pennsylvania for fifty-eight years, was graduated from the College of Physicians and Surgeons, Baltimore, Maryland, in 1888, being licensed to practice medicine in West Virginia the same year.

HARLAN HERBERT STAATS, M. D.

Dr. Harlan Herbert Staats, 68, of Charleston, died September 30, 1944, in a Huntington Hospital, following a long illness. The immediate cause of death was acute myocardial failure.

Dr. Staats was born at Mill Creek, near Ripley, in Jackson county, and was graduated from Barnes Medical College of St. Louis in 1899, being licensed to practice in West Virginia the same year. Following a year's practice at Ripley, he organized a hospital at Spencer in 1902.

He was commissioned in the Army Medical Corps in World War I and served as a plastic surgeon with evacuation hospital No. 41, being honorably discharged with the rank of captain after the signing of the Armistice in 1918. Returning to Spencer, he reorganized his hospital and practiced there until 1921, when he moved to Charleston. In 1923 he founded Staats Hospital, in Charleston, of which he served as president until his death. He was an honorary member of the Kanawha County Medical Society, West Virginia State Medical Association, and the American Medical Association. He was a 32nd degree Mason, and a member of Beni Kedem Shrine and the Knights of Pythias.

Besides his widow, Pauline (Flesher) Staats, he is survived by five children, Mrs. Herbert M. Beddow, of Charleston, and Mrs. Harry Sullivan, of Santa Rosa, California; Capt. Charles E. Staats (MC), of Charleston, now stationed in the Aleutians; Beverly W. Staats, of Kansas City, Missouri; and Harlan H. Staats, Jr., now with the armed forces at Camp Hood, Texas. One brother, E. R. Staats, of Parkersburg, and three sisters, Mrs. P. D. Fisher, of Charleston, Mrs. Warren H. Hodges, Seattle, Washington, and Mrs. Herbert C. Gladrow, of Santa Rosa, California, also survive.

Funeral services were conducted October 2, at the Bartlett mortuary chapel, in Charleston, with the Rev. John Beddow and the Rev. P. D. Fisher officiating. The body was interred in the family cemetery at Ripley. Members of the Kanawha Medical Society served as honorary pallbearers.

FORUM ON ALLERGY

The seventh annual Forum on Allergy will be held at the Hotel William Penn, Pittsburgh, Pennsylvania, Saturday and Sunday, January 20-21, 1945. At this meeting physicians will be given an opportunity to bring themselves up to date in this rapidly advancing branch of medicine by two days of intensive postgraduate instruction. The twelve study groups, any two of which are open to the physician, are divided so that those dealing with ophthalmology and otolaryngology, pediatrics, internal medicine, dermatology and allergy run consecutively. Further information may be obtained from Dr. Jonathan Forman, Director, 956 Bryden Road, Columbus 5, Ohio.

NEW HEALTH OFFICER IN BERKELEY

Dr G. P. Morison, of Charles Town, has been appointed as part-time health officer for Berkeley County, to succeed Dr. H. R. Dupuy, of Martinsburg.

Woman's Auxiliary

EXECUTIVE BOARD MEETS

A meeting of the Executive Board of the Woman's Auxiliary to the West Virginia State Medical Association was held at the Daniel Boone Hotel, Charleston, October 3, at 10 A. M., with Mrs. Scott A. Ford, President, presiding. The meeting was attended by the following members: Mesdames P. C. Spangler, U. G. McClure, D. T. Moore, G. A. Ratcliff, R. P. Daniel, H. P. Evans, H. V. Thomas, W. E. Hoffman, Herbert Beddow, V. E. Holcombe, C. T. Clark, R. S. McLaughlin, J. W. Carney, and W. R. Counts.

Mrs. Dana T. Moore, of Parkersburg, was elected Recording Secretary to succeed Mrs. Archbold M. Jones, of that city, resigned. Mrs. Frank J. Holroyd, of Princeton, was named as chairman of the Committee on Finance to succeed Mrs. Moore.

The meeting was followed by a luncheon at which the Auxiliary to the Kanawha Medical Society was hostess. Nearly 70 members and guests were present.

Mrs. Luther H. Kice, of Garden City, Long Island, National Auxiliary chairman of Legislation, was present and spoke on the "National Aspects of Medical Legislation." Proposed state medical legislation was discussed by Mr. Charles Lively, Executive Secretary of the State Medical Association.

Arrangements for the luncheon were in charge of Mrs. Ralph S. McLaughlin, President of the Auxiliary to the Kanawha Medical Society.

LEWIS COUNTY

The regular monthly meeting of the Woman's Auxiliary to the Lewis County Medical Society was held at the home of Mrs. Clyde Heater, in Weston, September 23. The luncheon meeting was attended by six members and three guests. Mrs. E. A. Trinkle, presided as president. At the general business session, members were urged to subscribe to The Bulletin, and plans were discussed concerning the Executive board meeting held in Charleston, Tuesday, October 3.

MRS. GEORGE SNYDER, *Secretary*.

MARION COUNTY

Dr. James A. Dolce, Marion county health officer, was the principal speaker at the regular monthly meeting of the Woman's Auxiliary to the Marion County Medical Society, held at the Fairmont Hotel, Fairmont, September 26, with Mrs. W. W. Orr, presiding as president. His subject was, "The Functions and Program of the Health Department." The meeting was attended by eighteen members and two guests.

The following officers were elected for the ensuing year: President elect, Mrs. L. D. Norris; vice president, Mrs. J. E. Offner; secretary, Mrs. K. L. Van Horn; Treasurer, Mrs. Joe Yost.

Committee chairmen were named as follows: Program, Mrs. George Traugh; Legislation, Mrs. H. S. Keister; Hygeia, Mrs. J. P. Trach; Bulletin, Mrs. E. W. Hickson; Publicity, Mrs. J. R. Tuckwiller; Historian, Mrs. K. Y. Swisher; Parliamentarian, Mrs. C. L. Parks; Telephone, Mrs. David Bressler; Hospitality, Mrs. J. E. Offner; Corresponding Secretary, Mrs. W. S. Welton; Membership, Mrs. L. D. Norris; Red Cross, Mrs. E. P. Smith; Tuberculosis Association, Mrs. Joe Yost; Community Council, Mrs. W. W. Orr; and Public Relations, Mrs. Ford Rogers.

MRS. K. L. VAN HORN, *Secretary*.

RALEIGH COUNTY

Mrs. S. A. Ford, President of the Woman's Auxiliary to the West Virginia State Medical Association, was the guest speaker at the regular monthly meeting of the Auxiliary to the Raleigh County Medical Society, held at the Beckley Hotel, Beckley, October 16. Her subject was the "Origin of the Medical Auxiliary." Mrs. L. E. Shrewsbury, president, presided at the meeting which was attended by 20 members and one guest.

Th program for the ensuing year was planned, and the sum of $20 was directed to be contributed to the Raleigh County War Fund. The next meeting will be held November 20, at the Beckley Hotel.

MRS. WM. C. COVEY, *Secretary*.

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And now, can't *you* do something more than you do? Are you inclined to forget Mrs. A. because her husband is away and inviting her makes an uneven number at your table? Do you call her occasionally to find out how she is getting along? Do you remember to ask, when you see her, what she has heard from her husband, how he is, where he is if she can tell you if you are interested? These things help to make him seem not so far away to her and they give you a vicarious interest in the war. —*Quarterly Courier* published by the Woman's Auxiliary to the California Med. Assn.

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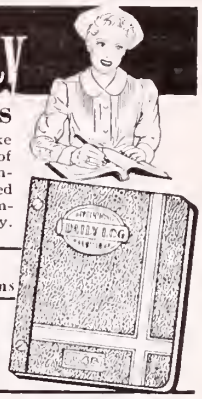

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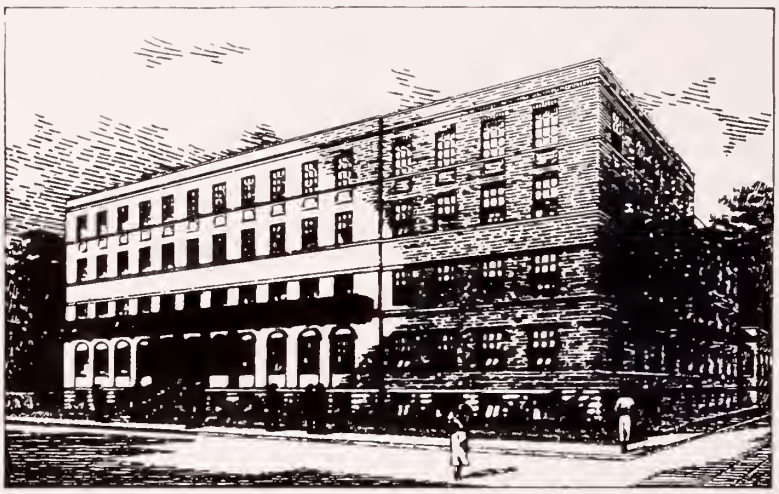

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TUBERCULOSIS IN WEST VIRGINIA INDUSTRIES

By J. T. DUNCAN, M. D., and C. SCOTT McKINLEY, M. D.
Charleston, West Virginia

WITHIN recent years the development of the paper x-ray film and the technique of photographing the fluoroscopic image, have greatly reduced the cost of x-raying the chest. As a result it became possible to make rapid surveys of population groups for tuberculosis. Probably the most extensive of the earlier surveys was made by the Bureau of Tuberculosis of New York City, paper films being used. Many population groups have been surveyed in New York City since 1933, including high school and college students, NYA employees, civil service employees, union members, prisoners, persons on relief rolls, and transients,—a total of 160,000 persons by the end of 1939. Since the development of photofluorography, surveys of population groups have become much more frequent. Since 1940 the most extensive surveys have been those made by the Army and Navy examining boards with relation to draft selectees, and by the U. S. Public Health Service in the interest of industrial employees.

There are a number of reasons for the current interest in industrial x-ray surveys.

THE AUTHOR

Dr. McKinley, graduate University of Pennsylvania; interned Hospital of University of Pennsylvania; American Public Health Association; American Association of Industrial Physicians and Surgeons; Association of Governmental Industrial Hygienists; Director Bureau of Industrial Hygiene, State Health Department.

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From the standpoint of the long term tuberculosis program, industrial surveys constitute an excellent case-finding procedure because the relatively low economic standard of industrial workers leads to a fairly high incidence of tuberculosis and, in consequence, a relatively productive program results. Statistics published by the National Tuberculosis Association long have indicated that unskilled laborers have a very high incidence of tuberculosis, and that even though the inci-

dence is much lower in skilled workers, it is still above that for agricultural workers and far above that for the professional or white collar class. Probably the most immediate and urgent reason for the current attention to industrial surveys, however, is the war production program. Great numbers of migrant laborers are working long hours and living under excessively crowded conditions and to these may be added the increased number of women employees particularly those in the 20 to 35 age group, which is the age group of highest incidence of tuberculosis in women. In addition there is the lure of full employment and high wages which tends to siphon off the minimal cases (or those with comparatively few symptoms) from the sanatoria before they have completed their cure. There is also the effect that migrating workers and shifting population have on breaking down the supervision and contacts of health workers with the known cases of tuberculosis, not to mention the fact that there is a decreasing number of public health nurses and full time health officers to handle the more complicated problem. The combination of these potentially dangerous factors, some leading to an increase in the susceptibility of groups to tuberculosis, and others producing an increase in the intensity and duration of potential contact to tuberculosis, may lead to an increase in the tuberculosis death rate. Now is the time, during the lag period before the increase occurs, to set in motion a case-finding and control program in industry which will serve to counteract this trend.

INDUSTRIAL SURVEYS IN WEST VIRGINIA

This, then, is the background which has led us to initiate industrial surveys on a rather limited scale in West Virginia from January to March, 1944. During this short period four industrial plants (two large and two medium sized) with a total labor force of approximately 7,600, were surveyed. Of this number 6,569 or approximately 86 per cent were x-rayed. The State Mobile X-ray Unit, which takes 4 by 5 inch photoroentgenographs was used in the survey. All positive or doubtful cases were re-x-rayed with 14 by 17 inch films. Five hundred and fifty-five of these large films were made,—8.5 per cent of the total. The industries chosen for the survey were picked primarily because they were engaged in war production, were interested in having the survey made, and were conveniently located. It would have been easily possible to x-ray many other industrial groups in addition to those chosen if we had had the time, since management is easily persuaded of the benefits to be derived. However, three months was the limit which we felt could be spared from our regular clinic schedule.

Three of the plants surveyed were in Kanawha County and the fourth was in Mason County. The diagnosis of tuberculosis and of other conditions found during the surveys were reported to the medical director of the plant, when there was a director, and to the county health officer of the county in which the survey was made. If the plant did not have a medical director the diagnosis was reported to the private physician of the individual patient and to the county health department. Reports to the plant management were entirely general and statistical and did not refer to the individual patient by name.

RESULTS

Table 1

Plant	Number Employed	Number X-rayed	Per cent	Tuberculosis Cases Discovered			
				Total		Active	
				No.	%	No.	%
A	403	393	98	5	1.27	1	0.25
B	575	554	96	14	2.53	6	1.08
C	4520	3589	79.5	41	1.14	17	0.47
D	2128	2033	95	32	1.58	14	0.69
Total	7626	6569	86	92	1.40	38	0.58
Male		5882		82	1.40	33	0.56
Female		687		10	1.45	5	0.73

Large films 555 or 8.5 per cent of total

Table 1 shows the approximate total number of employees and the number and percentage x-rayed. The number of employees is only approximate since labor turnover produces a fluctuation even from day to day, and in the larger plants we spent from four to six weeks in the survey. Response was completely voluntary in Plant C and semi-voluntary in the others. By "semi-voluntary" we mean that some pressure was exerted toward the last of the survey in order to round up the

stragglers. In the smaller plants response was as close to 100 per cent as is likely to be secured, the absentees usually representing those who were ill or on vacation at the time of the survey. At least partial credit for the almost 100 per cent response in the smaller plants should be given to the Kanawha County Anti-Tuberculosis League which conducted educational campaigns in these plants prior to the survey.

Table 1 also shows the number of cases found and the incidence in per cent. Under the column "Active" we have included those cases in which the film indicated a reasonable question of activity as well as the cases which were definitely active. It will be noted in table 1 that the total number of tuberculosis cases is 92 or 1.4 per cent and the number of active cases is 38 or 0.58 per cent. This compares with an incidence of 7.0 per cent total and 1.3 per cent active in the furrier's union in New York City, 25 per cent of whose members were x-rayed several years ago. More recent surveys of 125,000 workers in eleven states by the U. S. Public Health Service have revealed a 1.3 per cent incidence of significant tuberculosis. A more recently published report of surveys of the U. S. Public Health Service among industries in Cleveland has indicated a 1.25 per cent total incidence, and 0.6 per cent active or questionably active among 24,736 employees. The agreement between these figures and ours is remarkably close.

Table 2

Plant	Suspects for Tuberculosis No.	Suspects for Tuberculosis %	Heart and Aorta No.	Heart and Aorta % of Total X-rays	Other Pathological Pulmonary conditions No.	Other Pathological Pulmonary conditions %
A	5	1.27	26	6.5	12	3.06
B	5	0.91	40	7.2	9	1.63
C	48	1.06	261	7.3	21	0.59
D	30	1.41	176	8.2	39	1.92
Total	88	1.3	503	7.6	81	0.93

Other pulmonary conditions include virus pneumonia 24 cases; pneumoconiosis or silicosis 17 cases; arc welder's nodulation 11 cases; bronchiectasis 4 cases; lung abcess 1 case; other conditions 24.

In addition to the definite cases of tuberculosis there were 88 or 1.3 per cent of the total who were regarded as "suspects" as indicated in table 2. Many of these cases are duplicated under the column headed "Other Pulmonary Conditions" since the differential diagnosis was frequently not completed at the time of the survey. During our survey of the plant in Mason County an epidemic of virus pneumonia was apparently in progress and a number of these cases were seen. Except where we were able to get repeat films in a few weeks and note clearing, these cases were all called tuberculosis suspects on the basis of the single films.

The column "Heart and Aorta" includes all definite or suspected abnormalities of the cardiac or aortic silhouette, either in size or shape. A similar survey of 22,000 individuals in New York City revealed 6 per cent with cardiac or aortic abnormalities. This compares with 7.6 per cent in our survey. In the New York study after careful physical examination and thorough study of those whose x-rays showed abnormalities, 80 per cent were found to have corroborative evidence of cardiac disease. In our survey these persons were either checked by the plant physician or referred to their family physician for examination. No figures are yet available as to the actual number of cases of heart disease found. A selective factor may be in operation here to account for the surprisingly high incidence of cardiac abnormalities since undoubtedly many men now in industry have been rejected by the Army, some of them undoubtedly for abnormal cardiac shadows.

Table 3

	Total Cases	Per cent of Total Cases	Active	Inactive	Per cent of Active Cases
Minimal	62	67	25	37	40
Mod. Adv.	26	28	9	17	34
Far Adv.	4	4	4	0	100
Total	92	100	38	54	41

Of the total cases of tuberculosis 67 per cent were minimal, 28 per cent moderately advanced and 4 per cent far advanced, as shown in table 3. Of the minimal cases 40 per cent were regarded as active or questionably active. This figure was 34 per cent for moderately advanced and 100 per cent for far advanced.

The age distribution is shown in table 4 by broad age groupings. As indicated, the majority of active cases occurred in the 25 to 44 age group. This is consistent with the fact

that the vast majority of men in industry fall in this age group. The incidence rate, however, increased with age, the highest rate occurring in the age group of 45 or over.

Taable 4—Distribution

Total X-rayed		Total Cases of Tuberculosis		Incidence Rate in Per cent		Active Cases		Incidence Rate	Distribution of Cases	Age
M.	F.	M.	F.	M.	F.					
25-44	4072	289	53	5	1.30	1.73	25	0.57	66.0	
15-24	649	359	5	3	0.77	0.84	5	0.46	13.2	
45 plus	1109	32	24	2	2.17	6.25	8	0.70	21.0	
Age unknown	52	7								

(Colored—Total X-rayed 17—no cases of tuberculosis)

Of course, too few cases occurred among females to give a statistically sound comparison with males.

FOLLOW-UP

In the plants which had medical directors, follow-up of suspects and cases definitely diagnosed was carried on by the medical department of the plant in cooperation with the private physician in certain instances, and with the county health department. Although this paper was written within two months of the completion of the survey, we have already received a copy of a report from one medical department giving results of follow-up in that plant to date. This follow-up was very thorough for it included complete physical examination or re-x-ray of 389 persons out of 3,589, or better than 10 per cent of those x-rayed. Suspected heart lesions and non-tuberculous lung diseases as well as tuberculosis and suspected tuberculosis were included in the follow-up. Other patients from some of the smaller plants already have been re-x-rayed in county health department x-ray clinics.

SELECTIVE FACTORS AFFECTING SURVEYS

In view of the fact that few surveys of large groups are ever 100 per cent complete, the possibility of a selective factor operating in one or another direction must always be considered. In which direction will selective factors operate and how much will they affect the incidence rate? There is a well recognized psychological reaction to any unpleasant situation which is frequently encountered among tuberculosis patients, — the refusal to face facts. Such persons will frequently state, "If I had tuberculosis I wouldn't want to know it", and will resist all advice to be x-rayed. There may be others who have been definitely diagnosed as having tuberculosis and who are working in spite of medical advice. Naturally such persons will evade x-ray if at all possible. There is always a certain percentage of absenteeism because of illness and these persons frequently are missed in the survey. Of these ill persons the percentage having tuberculosis will be small but undoubtedly it will be larger than the incidence per cent for the well individual. All these factors tend to reduce the incidence rate when the survey is less than 100 per cent complete.

On the other hand, if a survey were only 50 per cent or less complete, there may be a selection in the reverse direction, since many patients with symptoms suggesting tuberculosis may make a special effort to be x-rayed. This may help to explain the fairly high incidence of tuberculosis in the previously mentioned survey of furriers' union members in New York City, a group in which only 25 per cent were x-rayed.

RELATION OF TUBERCULOSIS TO OCCUPATION

Tuberculosis, generally speaking, is not an occupational disease, if by an occupational disease we mean one that arises out of and in the course of employment. Of course, under certain circumstances, unusual contact may be brought about by occupation such as in the field of nursing or medicine, and it then can be considered an occupational disease. This situation is unusual in industry. Tuberculosis, however, is a well known complication of silicosis and the combination is frequently compensable although the tuberculosis may have no definite relation to employment except for its predilection for lungs weakened by occupationally produced silicosis.

Employment of the person with reinfection tuberculosis (the adult type), presupposes medical supervision. It has been maintained that persons with quiescent or an arrested case of tuberculosis should not be employed in any organization where automatic medical supervision is not assured. This is a narrow viewpoint and unjust to the

victim of tuberculosis. As more and more early cases of tuberculosis are found, there will be an increasing number of individuals who have been "cured" and who are capable of productive work. Since the majority of small plants do not have either a full time or part time physician, and may not even have a nurse, and since a very high percentage of workers are employed in these plants, it seems unwise and unjust to penalize these individuals by preventing employment after they have undergone satisfactory treatment. All emphasis these days is on early treatment, thus increasing chances of "cure", decreasing spread, and increasing opportunity for return to self-support. Tuberculosis patients who have undergone treatment in a good sanitarium generally have an excellent knowledge of their disease and desire to cooperate with those interested in their welfare. If a private physician or possibly a clinic will take charge of these individuals and adequately check them when they return to work, there should be no undue hazard associated with their return, even if the industry has no medical department.

EMPLOYMENT OF THE TUBERCULOSIS INDIVIDUAL

The employment and the type of work an individual should do can be further classified according to activity and degree of pulmonary involvement. Of course no person with an active lesion should be employed or allowed to continue working. If the pulmonary involvement is classified as far advanced, industrial employment is probably unwise even if the disease is apparently stable. Patients with arrested or quiescent pulmonary tuberculosis of less extent should not be employed at more than moderate physical work, preferably sedentary. However, if the pulmonary disease is healed and stable, employment may be allowed at most types of work except those involving marked or extreme physical effort.

An individual with a suspicious pulmonary lesion should undergo studies and periodic examination in order that a final diagnosis may be reached. Decision concerning employability or advisability of continuing employment should be withheld pending this final diagnosis. Often a period of hospital or sanitarium study is advisable but frequently the patient can continue on the job while he is under observation. Discharge of such persons from employment defeats the objectives of the program since it frequently results in the patient being lost from supervision without final diagnosis and without final recommendations concerning treatment.

Individuals with adult type of tuberculosis, even though healed and stable, should not be employed in an area where there is exposure to silica dust. It is also probably unwise for such individuals to work where there will be excessive exposure to pulmonary irritants or inert dusts.

FOLLOW-UP EXAMINATIONS

Frequency of check-ups will depend on the recency of pulmonary activity. On first returning to work a monthly check-up should be insisted upon. This should include temperature, weight, blood counts, and questioning concerning health and symptoms. An x-ray, and if practicable, a sedimentation rate, should be taken before commencing work and at three month intervals thereafter. The frequency of the examination can be decreased as time elapses after the lesion has attained stability. However, check-ups should never be less frequent than once a year and these annual examinations should be continued indefinitely. Following respiratory diseases, except those of trifling character, a chest x-ray is in order and may uncover a reactivated lesion that might otherwise have gone unnoticed for months.

If a program such as that outlined in this paper can be carried out by the plant medical department, private physician, or clinic, most "cured" tuberculosis patients can work in industry with benefit to themselves, labor, management, and the community. Such a program will be of further help in removing the stigma connected with this disease which even in this day and age has not been completely lost.

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NEWER METHODS OF COMMUNICABLE DISEASE CONTOL*

By L. F. BADGER, M. D.
Medical Director United States Public Health Service
Bethesda, Maryland

RATIONAL measure for the control of communicable diseases must be based on exact knowledge of the specific disease. As advances in medical science add to our understanding of the factors involved, our methods of control and our laws and regulations implementing such control must keep pace with the newer knowledge. With this in view, the American Public Health Association has made available, from time to time, information to aid the health officer, the board of health, and legislative body having the power to make rules and regulations dealing with the control of communicable diseases. This information is prepared by a Committee on Standards, and is so arranged that the user can "by reference to the description of the disease and recommendations for methods of control easily prepare the necessary text upon which the educational and administrative acts of the health officer will be based."[1] In making the report, the Committee has refrained from preparing formal regulations under each disease since the laws under which various boards of health operate require differences in the legal phraseology of regulations. But the information presented is fundamental and upon these data all legal measures are based. The first of these reports, compiled by the American Public Health Association Committee on Standard Regulations appointed in October 1916, was published in 1917[1]. Herein each disease listed is briefly described, and information such as the etiological agent, source of infection, mode of transmission, incubation period, and period of communicability stated. Methods of control also are discussed. The report was revised during 1926[1] to reconcile it with advances in medical sciences made during the nine year interval since it was first published. A further revision was made nine years later by the Subcommittee on Communicable Disease Control of the Committee on Research and Standards of the American Public Health Association and officially approved by the United States Public Health Service.[3] The latest report bears the date 1940[4], and even now a revision is needed and is being considered.

Inasmuch as such provision is made for the formulation of adequate and uniform laws pertaining to the control of disease, I shall discuss the control of communicable disease from angles other than the regulatory aspects.

Although knowledge of the etiological agent, incubation period, period of commun-

*Presented before the West Virginia State Health Conference, Charleston, May 1, 1944.

THE AUTHOR

Dr. Badger, Medical Director USPHS, Bethesda, Maryland; graduate University of Minnesota; interned Minneapolis General Hospital. American Society Tropical Medicine; A.A.A.S.

icability, susceptibility and immunity, and prevalence is essential to the prevention of spread of a particular disease, I believe that recognition of the disease, source of infection, mode of transmission, and immunization probably are the factors of greatest importance to the enforcing officer. To successfully control a communicable disease, the disease must first be recognized and identified, the source of infection must be eliminated, the routes of transmission interrupted, and the susceptible population immunized. It is with regard to these measures that the greatest advances have been made in recent years.

RECOGNITION OF THE DISEASE

Recognition of the disease should apply not only to clinical cases but to carriers as well. New laboratory procedures have been developed which are of significant aid in the identification of cases and carriers of many diseases. Among the newer procedures the following will be of interest: New differential media have been developed for aid in diphtheria and dysentery diagnoses; by employing chick embryo as a culture medium smallpox and chickenpox now can be differentiated, as smallpox virus produces lesions on the membrane while chickenpox virus does not; complement fixation tests for diagnosis of equine encephalitis and influenza are now employed.

The location of cases and carriers may be considered with the recognition of the disease. An outstanding example of the recent development of aids in the location of infectious cases is the method which is applied to tuberculosis case-finding. The standard x-ray procedure, using a 14 by 17 inch film, at present unanimously considered the most accurate method for early diagnosis of pulmonary tuberculosis, is too costly for use on a large scale. The discovery of individuals with symptomless tuberculosis can be made quickly and certainly by universal mass radiography which is accomplished by the use of small films.

As with tuberculosis, the first essential in the control of venereal disease is the location of infectious cases. The importance of epidemiological investigations and the tracing of contacts to the source of infection in the control of these disease has been well demonstrated. The most advanced methods of diagnosis and treatment will do little toward ultimate control unless the majority of infected cases are located and treated—treated to the extent that they are no longer infectious. Venereal disease cannot be controlled without, first, uncovering infected cases and, second, getting these cases to the physician or clinic for treatment.

SOURCE OF INFECTION

To successfully control the communicable diseases, sources of infection must be eradicated. This can be accomplished by isolation and quarantine of the infected individual and by employing therapeutic measures aimed toward shortening the communicable period and eliminating the carrier. It is in the treatment of cases and carriers that recent advances have been made—notably the development of the sulfa group of drugs and penicillin. The most promising results have been obtained by the use of these agents in the treatment of venereal diseases, dysenteries, pneumonias, streptococcic throat infections, scarlet fever, and meningitis.

A discussion of the employment of the sulfa drugs in the treatment of the dysenteries will well illustrate their value in the elimination of sources of infection.

It is now felt that the spread of endemic dysenteries is almost entirely by person to person contact—by direct spread from cases and carriers to uninfected individuals. Flies as transmitting agents cannot be ruled out and probably are the vehicle of transmission in some instances, but apparently they are not as important as generally believed. Water, food, and milk are possibly of less importance than generally believed as the means by which endemic dysentery is communicated.

Outbreaks of epidemic dysentery are rarely explosive. The important point is that the usual epidemic is one which begins with spor-

adic cases which gradually increase in number. These initial cases usually precede the recognized outbreaks by from two to six weeks. The picture is one of spread by direct person to person contact. Control of dysentery may be based on two methods of attack: nonspecific and specific. The nonspecific are those procedures which are designed to limit the exposure to human excretions—satisfactory sewage disposal systems and satisfactory facilities for personal hygiene. If these are available dysentery problems will not be of great significance. Although these are methods of choice, there are at times situations when they are not available or cannot be applied effectively. In such situations specific methods must be employed. There are two procedures which may be followed in the specific control:

1. *Treatment with laboratory control.* This procedure is the one of choice if practical and if the facilities are available. Cultures should be made on all members of the group and treatment of cases with suspicious cultures instituted. Cultures should be repeated after three, five, and ten days of observation, and treatment of those with positive cultures continued.

2. *Mass therapy.* If laboratory control is not feasible the procedure of mass therapy may be adopted. The entire group should be treated with small doses of the selected drug for five or six days. This method has been used effectively in institutional groups and although not a very desirable procedure, there are many circumstances in which it might be the method of choice.

The occurrence of one or two cases of diarrhea in an institution should be a warning and cultures should be taken. If positive cultures are obtained and if many more cases develop, a search for carriers in the group should be made. All persons with positive cultures and their contacts must be placed under treatment. With an outbreak under way, isolation and treatment of clinical cases only will not prove sufficient as there are always too many asymptomatic carriers in adult and older-children groups.

Many sulfonamides are effective in the treatment of cases and carriers. With our present knowledge, sulfadiazine and sufapyrazine seem to be the most efficacious. The dose to be used can be relatively small, 3 to 4 gms. per day for an adult. Some infections require from seven to eight days' treatment. In Flexner dysentery infections, four days' treatment will usually suffice. At present there is no information relative to the treatment of Shiga infections with this group of drugs. Salmonella infections, the common cause of explosive outbreaks, as well as endemic cases of infectious diarrhea are not affected by the sulfa drugs.

The sulfa drugs and penicillin have proved of considerable aid in the treatment and, indirectly, in the control of venereal disease. Penicillin has been employed in the treatment of a limited number of cases of syphilis and the early reports indicate that it may ultimately prove to be extremely useful in the therapy of this disease.

At no time have there been available as many effective agents for the treatment of gonorrhea as at present. The sulfonamide drugs have a definite place in the treatment of this disease, although experience has proved them to be less consistently effective than we hoped. Penicillin has been effective in the treatment of sulfa-resistant cases. The role of these agents in the treatment of gonorrhea is not yet determined, but available evidence suggests that with their use a procedure of treatment more effective, less tedious and of shorter duration is possible. The fact that the treatment is of shorter duration has proved of great advantage in that more patients are willing to continue treatment until cured, which results in a great reduction in the number of infective cases.

INTERRUPTION OF ROUTES OF TRANSMISSION

The recent advancements made in the interruption of routes of transmission are related to those communicable diseases which have an intermediate host or insect vector.

The war has stimulated the development and improvement in methods of application of extremely effective larvicides and insecticides. The results obtained so far give great promise toward the control and elimination of such diseases.

IMMUNIZATION OF SUSCEPTIBLE POPULATIONS

In recent years there have been some advances made in methods for the determination of persons who are definitely susceptible to a particular disease. Complement fixation procedures and serum protection tests have been developed for diseases for which previously no such tests were available. These tests may be employed in determining, among population or restricted groups, those individuals who are susceptible to influenza, equine encephalitis, spotted fever, typhus fever, and Q fever. Also, results obtained in recent investigations suggest that there are now available skin tests for the determination of a child's susceptibility to pertussis and mumps.

Some of the vaccines which have been employed for many years have been improved. The typhoid fever vaccine now in general use appears to be superior in protective properties to the vaccines employed in the past. This change has been brought about by selecting more virulent strains with which the vaccines are prepared.

For some time the degree of efficacy of pertussis vaccine has been debated. As the result of improvement in its manufacture there is now a vaccine which appears to be of definite value.

Several groups of investigators are now working toward the development of a vaccine which will be useful in protection against influenza. It can be stated that the results so far obtained are promising.

New methods of prophylaxis other than vaccination have been tried out and results obtained which might lead to measures of value in the control of some of the communicable diseases. Prophylactic employment of sulfadiazine might have some merit in the prevention of scarlet fever and meningitis. The results of a study carried on among school children suggest that the use of ultraviolet irradiation and aerosols may prove important in the interruption of routes of transmission of chickenpox and measles.

SUMMARY

New aids in the control of communicable diseases have been mentioned and some briefly discussed.

New laboratory diagnostic aids in the recognition of communicable diseases have been devised. Tests applied to some diseases have been found applicable to others.

New case-finding technics have been developed; increased stress has been placed on the tracing of contacts.

Recently developed therapeutic agents have been shown to be of value in eliminating sources of infection, both clinical cases and carriers.

New agents have been shown to be applicable in interrupting routes of transmission.

Advances have been made in methods of determining susceptible persons in the population and of immunization of these individuals.

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FOOD REQUIREMENTS FOR THE AGED

The moderate use of condiments, broth, and relishes are useful in stimulating the appetite of the aged. A simple plan for meeting the requirements of essential nutritive factors should be followed. Such a plan might include a pint of milk daily which may be utilized in creamed soups, puddings, milk toast, cheese, and ice cream; one or more servings of fruit, either raw or cooked; a serving of potatoes; two servings of yellow, leafy and green vegetables, either cooked or raw as in salads, a serving of whole grain cereal such as oatmeal or wheat; if possible, one egg daily; a serving of meat, fowl, fish, liver, or other high protein food, preferably with a moderate amount of fats, and sweets in moderation, butter or olemargarine with vitamin A, and peanut butter. Vitamin supplements may prove useful in patients maintained on low calorie diets because of obesity. —*Nutritional Observatory*.

OBSERVATIONS ON IMPROVED DISEASE CONTROL METHODS AMONG TROOPS*

By JOHN W. R. NORTON, Lt. Col., MC.
Preventive Medicine Service, Office of the Surgeon General, United States Army

THOSE of us who have had even a minor part in connection with the preparation and execution of previous D-Day medical plans perhaps appear peculiarly uncommunicative now that everyone is so intensely interested in the main D-Day. The North African and Sicilian operations, in which I participated, now appear in retrospect (as Mr. Churchill said at the time) "the end of the beginning." The Pacific experiences, possibly even more than those in the Mediterranean, have served to emphasize the importance of preventive medicine in modern streamlined mechanized warfare. It is difficult for the civilian physician to realize the extent to which all medical officers of our armed forces are responsible for preventing, as well as treating, diseases and injuries. Because of security considerations, we have to confine our discussions to rather general terms, and this is particularly true with regard to prevention and control of communicable diseases which have constituted the main threat to all armies. Our chief satisfaction at present must come from knowing that the medical work with our armed forces is being well done. Later, we can be more specific regarding how medical care has exerted, and will exert, its influence from El Alamein to Berlin and Tokyo.

Even though I saw injuries and diseases of great variety and was in and out of treatment stations and hospitals of all kinds, I had no direct responsibility for the treatment of diseases or battle casualties. Except for going through a few bombings and being torpedoed, I had no dramatic experiences in connection with my overseas duty. In fact, most of those who have been with our troops overseas look upon their work with the same matter-of-fact and objective view with which you men, who have taken on increased duties at home, regard your day-to-day activities. When the full story of medical care during this war is known, I feel sure that some of the most dramatic and heroic work will be known to have been done by some of the men providing medical care at home. One of the greatest satisfactions the men overseas have is that they feel their loved ones at home, as well as they, are receiving adequate medical care.

THE AUTHOR

Dr. Norton, formerly Professor of Public Health Administration, University of North Carolina School of Medicine; graduate Vanderbilt University School of Medicine; Public Health, Harvard University; recently medical inspector and member of preventive medicine division with the overseas forces.

I would like to mention a few steps in the progress which has been made in military medicine and particularly make some comparisons and contrasts between World War I and World War II. Our total annual death rate per 1,000 has improved as follows:

Mexican War....110
Civil War..... 65
Spanish War..... 26
World War I.... 19 (8.7 exclusive of influenza)
World War II (1943.5.5 (all disease about 0.6)

The case fatality rate for battle wounds during World War I was 7.7 per cent; for World War II, 3.1 per cent.

The total annual admission rates per 1,000 afford some interesting comparisons. (Quarters cases were not counted in World War I)

	War I	*War II*
All diseases	852	735
Common Respiratory Disease	325	226
Venereal Disease	86.7	41
Pneumonia	19	12.8
Tuberculosis	9.4	1.2

*Presented before the seventy-seventh annual meeting of the West Virginia State Medical Association, at Wheeling, West Virginia, May 16, 1944.

Diarrhea and Dysentery.....	6.6	21
Typhoid - Paratyphoid.....	0.4	0.04
Battle Casualties.....	50.0	5.0

It is observed that there has been more diarrhea and dysentery in World War II. We have also had more jaundice, sandfly fever, dengue fever, and filariasis. These changes are largely due to the difference in geographical areas of troops activities. In this war many more have been deployed in the more backward tropical or semitropical regions. The venereal disease case rate has been greatly reduced and the noneffective rate from this group of diseases has been even more markedly improved. The noticeable decrease in tuberculosis cases seems due principally to the more effective elimination of incipient cases from active military service.

Our troops did not participate in active combat on any considerable scale in this war prior to 1943 and a comparison of case fatality rates for our overseas troops in World War I and during 1943 is of interest.

	World War I	*World War II* (1943)
Meningitis	43%	4 %
Pneumonia	28%	0.7%

Our communicable disease deaths among overseas troops during 1943 were less than one-third of those from all diseases. Oddly enough, the commonest cause of "medical" deaths has not been some dramatic exotic disease, but has been due to heart (including coronary) disease. Only about one-half of the deaths from communicable disease were due to tropical disease. The deaths caused by non-battle injuries were five times those from all diseases in overseas theaters during 1943.

The general Army death rate has been reduced twice as much as would be expected in the comparisons of the same age and color groups from our civilian experience. While morbidity from non-battle injuries has been substantially the same, our death rates from non-battle injuries has increased 25 to 50 per cent on account of the more serious types of injuries incurred in handling aircraft and our more complete mechanization of our troops.

The great improvement in our case fatality rates for combat casualties and for disease has been brought about largely by rapid evacuation of the injured and sick to medical treatment facilities, by the use of plasma and whole blood transfusious, and through the great advances in our chemotherapy particularly sulfonamides and penicillin. It is also felt that the effective indoctrination in sanitary discipline and the availability of better sanitary discipline and of better sanitary devices have noticeaby reduced the spread of infection and probably also tended to produce a milder type of case. Our Medical Department personnel have been better trained and better placed than before. Our supply and transportation systems have made available effective tools where and when they have been most urgently needed. It is impossible to make any comparison between the devotion of medical personnel during this war and heretofore, but certainly the results produced indicate that we have just cause to continue to be proud of the work of our Medical Department personnel during this war.

Well trained and equipped enlisted men find the wounded, give first-aid and quickly bring these men back to the care of medical officers at treatment stations or hospitals. They splint fractures, stop hemorrhage, and prevent, or begin treatment for, shock. They apply first-aid bandages to wounds and when indicated they make local applications or give oral doses of sulfonamides. Even the soldier himself is taught to help himself or his buddy in doing a great many of the steps of first aid care.

The time elapsing between injury or onset of illness and the necessary definitive medical or surgical treatment has been enormously reduced during this war. Arrangements also are made whereby the patients promptly receive the necessary treatment as they are being evacuated to the rear. Terrain and weather difficulties often complicate the problem, but we have been able to adapt our

facilities to the needs in each particular situation. Almost every conceivable method of carrying patients has been used: hand carry, wheel litters, pack animals, jeeps, ambulances, trains, "ducks"—big and little, landing craft or other small boats, hospital ships and transports, and air transport. In amphibious operations, those wounded on their way to the beaches are kept in the landing craft and returned to the care of medical personnel in the larger boats. As soon as a beachhead is established, giving sufficient freedom of operation, medical care facilities are set up on the beach and these are augmented as beachhead is enlarged, first with dressing stations, then increasing with facilities of medical battalions and hospital units. As soon as practicable, hospital ships come in to be loaded with patients. When it is safe and air strips are available, air evacuation begins. Specialized teams of auxiliary surgical units move in quickly with their equipment to strengthen the medical battalions and field hospitals. If establishment of the beachhead is successful, patients may be evacuated by air and by hospital ship within a few days after the initial landing.

Nurses serve on boats and beaches, in planes, and wherever they are needed. They ask no favoritism and they practice no evasion when the going is tough. Several whom I knew overseas will not be coming back. Their quiet efficiency and their presence in combat zones stimulated morale as nothing else could.

Plasma and blood banks and the improved general treatment of shock cases have increased individual resistance and made life-saving operations possible in what would formerly have been inoperable cases.

The use of sulfonamides and penicillin in selected cases has reduced hospital admissions, shortened hospitalization, and lowered case fatality rates.

Most of us, when thinking of the hazards of field operations in the tropics, tend to think too much of the heat and other weather problems, but actually insects constitute the chief threat to comfort and even to life itself. Without going into details, it can be said that some of our greatest progress in medical care has been achieved through better control of insect-borne diseases. Our new repellents and insecticides are truly miraculous in their ease of application and in their effectiveness. Consider, for instance, the delousing of a million and a half persons in Naples to halt a threatened epidemic of typhus, which, though not a tropical disease, yields to similar control methods.

Our venereal disease rates overseas have not been greatly different from those here at home.

The nutritional and neuropsychiatric care of troops is being constantly improved. Restoration of men to full effectiveness is repeatedly aimed at from the onset of disease or injury, and when necessary includes convalescent and rehabilitation care. Assignment of trained medical inspectors and neuropsychiatrists to divisions and larger units has greatly improved communicable disease control and mental hygiene services for troops in the field.

RAPIDLY-MOVING WARFARE

Our Medical Department personnel and equipment have been speedily adapted to modern rapidly-moving warfare. Our communications, packaging and distribution of supplies, and vehicles have not only kept pace with efficiency requirements, but in certain cases our medical supply depots have been established and in operation ahead of those for food and ammunition.

The Army, Navy, U. S. Public Health Service, Veterans' Administration, State Health Departments, and representatives of civilian medical practice have already worked out tentative plans for guarding the health of those being separated from active duty as well as protecting the communities to which discharged men already have begun to return. In so far as possible, plans are being worked out and facilities are being provided to insure that the change in our country from all-out war to a peace time basis will be

smoothly carried out. Civilian physicians, more than any other group, have a great resposibility and a greater opportunity in connection with the readjustment of service men returning to their home communities. Doctors are able to understand the physical, mental and emotional stress and strain to which men in our armed forces have been and are being subjected. Our peace-loving and home-loving population have found it difficult to adapt themselves to the conditions of modern warfare; a large number of our returning troops, particularly those who have had extended overseas service, may find the readaptation to life in their home communities even more difficult. No one else is quite so well equipped as the family doctor to be of real help at this crucial time in the lives of these men and women. The family physician will have to think of a great many more possibilities than formerly as he attempts to arrive at a differential diagnosis Doctors will have to familiarize themselves with tropical diseases and with mental and emotional strains. With certain exceptions, however, in the care of ex-service men, the medical history will be of unusual value. It will be particularly important to determine the tropical diseases which were prevalent in the areas where the individual has served and the special mental and emotional strains experienced.

Because of the use of tetanus toxoid among our armed forces, civilian physicians should use a stimulating dose of toxoid for preventive purposes rather than antitoxin as heretofore.

Demobilization will be carried out in such a way that we should have little hazard from the exotic diseases among our civilian population. With the maintenance of medical care adequate in quality and quantity for our armed forces and for civilians, there should be a minimum accumulation of neglected cases that heretofore after all wars has provided knotty problem for medical profession.

HYPERTHYROIDISM AND THIOURACIL

(CASE REPORT)

By FREDERICK R. WHITTLESEY, M. D.
Morgantown, West Virginia

THIS case is presented because of widespread interest in the new drug thiouracil, and the dramatic benefits it may produce.

The patient, a white female aged 57, had been suffering characteristic symptoms of hyperthyroidism for about two years. These symptoms included marked nervousness, palpitation, fatigue, sweating, and weight loss of 55 pounds. For somewhat less than a year there also had been symptoms of progressive myocardial failure, including peripheral edema, severe shortness of breath, and cough. Laboratory studies made shortly before my first examination had included basal metabolic rate which was plus 38 and an electrocardiogram in November 1943 which showed auricular fibrillation, and also changes indicative of coronary heart disease. Treatment had included digitalization and sedatives. No iodine had been used at any time. The patient's condition was such that surgical treatment was thought, by more than one surgeon, to be entirely too risky.

THE AUTHOR

Dr. Whittlesey, graduate Western Reserve University; postgraduate Harvard Medical School; teaching staff, West Virginia University School of Medicine; Fellow American College of Physicians.

I first saw the patient on May 10, 1944. Examination disclosed the following conditions: Weight 117 pounds, blood pressure 130 systolic and 84 diastolic, apical heart rate 120, fibrillation. Nervousness and dyspnea were marked. There was moderate exophthalmos and lid lag. Neck veins showed distention, and the thyroid was moderately

enlarged and adenomatous. The heart was enlarged to the left and the right. The lungs showed bilateral basal rales, and a moderate right hydrothorax. Fluoroscopy confirmed the clinical findings. The liver was slightly enlarged. There was marked tremor of the hands, and slight pitting edema of the ankles.

Sedatives only were prescribed, and the digitalis stopped. Through the courtesy of Lederle Laboratories a supply of thiouracil (Deracil, Lederle) was obtained, and treatment begun on June 3, 1944, using a dosage of .6 Gm daily. Subjective improvement was noticed in three or four days; the tension and nervousness decreased, and the harassing cough disappeared. One week from the start of treatment reexamination showed marked improvement. The apical rate had decreased to 102, and there were only a few rales at the right base, but still evidence of fluid. The cough, dyspnea, and edema had entirely disappeared. At this time the dosage of thiouracil was reduced to .4 Gm. per day. One week later the chest was free of fluid, and the apical rate 92. On June 22, basal metabolic rate was plus 7 and plus 11 on repeated determinations. In view of this the dosage was reduced to .2 Gm. per day. On June 24, the apical rate was 66, and has remained (though fibrillating) within normal limits ever since. Fluoroscopy on July 1, 1944, showed a considerable reduction in heart size, but enlargement was still present. The lungs were clear. Since that time steady improvement has been made, with a gradual regaining of weight and strength, and good control of all symptoms of hyperthyroidism of a maintenance dose of .1 Gm. of thiouracil per day. No change in the appearance or consistency of the thyroid has been noted, and no toxic effects ascribable to the drug have appeared.

SUMMARY

This case is one of progressive congestive heart failure due to hyperthyroidism with associated arteriosclerotic heart disease. Treatment with digitalis had been completely unavailing, and the patient's condition was steadily growing worse. Surgical intervention was thought unsafe, and the prognosis was altogether gloomy, as the patient herself well realized. In a very few days, under treatment with thiouracil, the symptoms began to improve, and in three weeks' time all signs of congestive failure were gone, and the symptoms of hyperthyroidism had to a great extent disappeared.

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PRIMARY CARCINOMA OF BOTH BREASTS

(CASE REPORT)

ROBERT K. BUFORD, M. D., and MATTHEW A. IATESTA, M. D.
Charleston, West Va.

THE patient, Mrs. F. W., a 38 year old white female, was first seen by R.K.B. fourteen years ago. At that time, at the age of 24, she had a tumor of moderate size on the right side of her neck which had been diagnosed by another physician as an adenoma of the thyroid. On careful examination, the thyroid gland was found to be normal in size and consistency. A tentative diagnosis of lymphosarcoma was made as x-ray of her chest showed mediastinal involvement. Unfortunately, no biopsy was done. She was advised of the seriousness of her condition, and was sent to Mayo Clinic for consultation. There the diagnosis of lymphosarcoma was confirmed. She was given a series of x-ray treatments by one of their Fellows in Indianapolis, which at that time was her home. Following this she came to Charleston, West Virginia, where she was given further x-ray therapy. In the following years, there was no evidence of recurrence, and she lived a normal life, giving birth to two healthy, normal sons.

In 1935, she discovered a tumor in her left breast. It was excised, examined, and found to be a fibro-adenoma. In September 1939, at the age of 32, she returned with a

small tumor in the lower outer quadrant of the right breast. This nodule was so small that it was difficult to palpate until it was pointed out by the patient. Careful examination revealed no involvement of the right axilla, nor of the right clavicular areas. She was given a series of x-ray treatments to the right breast and surrounding areas, plus a menopausal dose of x-ray. Following this a radical mastectomy was done. Frozen section at the time of operation showed the tumor to be a scirrhous carcinoma.

She was examined every three months thereafter for evidence of metastasis or recurrence. She continued to enjoy good health for almost five years until Feruary, 1944, when she discovered a small nodule in the medial aspect of the left breast. At that time it was so small that the examiner was unable to palpate any definite growth. She returned in April 1944, complaining of an aching in the left breast. The left axilla and the left clavicular spaces showed no evidence of metastasis. She was hospitalized and frozen section at the time of operation showed the condition to be that of scirrhous carcinoma. A left radical mastectomy was done, and x-ray therapy to the area will be given.

Although we shall never know definitely whether or not this patient had a lymphosarcoma, as no biopsy was done, our main interest in this case is the multiplicity of breast tumors. Also, it is not very common to accomplish a five year cure of a breast carcinoma in a 32 year old female. One of the important phases in the treatment of this case, we think, is the destruction of ovarian function by means of x-ray. There is a relationship between ovarian function and growth of breast carcinoma. It has been definitely demonstrated that carcinoma of the breast grows faster when estrogenic hormones are given. We believe also that surgical removal of both ovaries may be of further benefit in the treatment of breast malignancies.

It is the opinion of Dr. Walter Putschar, our pathologist, that the second breast carcinoma is not a metastasis of the right breast, but rather a second primary carcinoma. It has the microscopic characteristics of a primary maligancy, invading the milk ducts and the fatty tissue of the breast, and showing grossly finger-lke processes invading the surrounding structures. The fact that at one time a fiibro-adenoma had been found in the left breast, presents an example of the ocurrence of an unusual number of primary neoplastic lesions in the same individual.

SUMMARY

This case demonstrates the value of regular, periodic postoperative examinations in cases of malignancy, for in this way early recurrences or other primary malignancies may be more frequently detected. In addition, there is the value of educating the public concerning cancer, making individuals more cancer-conscious, as in the case of this patient, so that more often malignancies may be found in their early stages when therapy gives more gratifying results.

DOCTOR'S ROLE IN REHABILITATION

There are several steps in the successful handling of rehabilitation. The first necessity is proper medical attention after injury. This, as the profession and the press testify, the boys are getting from skilled physicians in foxholes, at front-line first aid stations, at hospitals, and at government hospitals. Once the injured veteran has been rehabilitated physically as much as is immediately possible by corrective surgery, mechanical appliances and neuropsychiatric treatment, he should be returned to his home community rather than to linger in a government hospital until treatment is completed.

The proper handling of the veteran on his return home constitutes the second step in rehabilitation. We believe that the only efficient and satisfactory method of completely returning our boys to normal living is to place them in the hands of their community physicians who, at government request, give of their time and skill gratitously to decide on the physical fitness of the boys who were inducted and who will exert themselves to the utmost to bring these boys back as close to normal as possible and who will decide just what jobs they can undertake to enable them to return to their self-supporting status of pre-war days.—*Canadian Doctor.*

The President's Page

"The tumult and the shouting dies." "Let those who mourn be comforted." This is still America, "the land of the free and the home of the brave," and in no other country could a fellow have as much fun, and cause so much commotion, just because he put a few of his OWN thoughts on paper. It never occurred to me that anyone could ever interpret the president's page other than the representative thoughts of a single individual.

Enough of the past. What of the future. Can that well worn expersion, "Too little and too late" be applied to organized (?) medicine? I think it can. If at this time, we had in working order a sound and satisfactory pre-payment plan to take care of the low wage earner and his family, and a similar plan with governmental aid for the medically indigent, do you think we would be facing socialized medicine? We certainly would not. To be sure there are numerous communities and industrial groups happily cooperating in such plans, but relatively speaking they represent only a small part of our population.

What I'm talking about must be universal, covering all people who are unable to bear the burden of the costs of medical care and hospitalization. And who is to blame? To put it mildly, let us say that those of us in the profession who have been apathetic, ultra conservative, short sighted, argumentative, suspicious of his brother, and perhaps a little selfish and fearful of a change, have been largely responsible. Oh! yes, there are some who say, "We have received no specific guidance from our holy of holies, but before anyone of you starts blaming somebody else, ask yourself this question. "What have I done to help keep our profession free and independent, and yet at the same time able to render adequate medical service to the low wage earner at a reasonable and nominal cost?

There are many who have worked hard and diligently and to them I offer my humble congratulations. They are still working, but now, all of us, if it is not too late, must get behind our committees and endorse a plan that must be presented to our next legislature, so that we may offer to the low wage earner of West Virginia what he so earnestly desires. If we do this, then, and only then, can we urge our congressmen to oppose the social legislation, scheduled to come up in Washington early in 1945. The New Deal has received a mandate from the people. The green light is on with the order to go ahead. The people want adequate low cost medical service. They would prefer that the practice of medicine remained free from government control, but they will take federal controlled medicine. What is your pleasure.

If this be heresy, make the most of it. I say lets get in or get out. Lets stop the parade if we can, but if we cannot, lets climb on the band wagon and ride to glory, instead of bringing up the rear blowing a tin horn and wearing a silly hat.

And now as I am about to leave you, may I thank all of you who have given so much of your time and efforts for the cause of medicine in West Virginia. Yours is a thankless task, devoid of praise and filled with criticism, but you have done a fine job and you have done it well. I trust your efforts will bear fruit in 1945.

To my old friend, Tom Harris, I wish the best of luck. You may have headaches, but none so great as the preparation of the President's Page. To offset those headaches you will experience a real joy in working with a cooperative medical profession for the betterment of medical services in West Virginia. The year 1945 will be a critical year. Let us hope that the prestige of the medical profession may rise ever higher in the heavens, taking the leadership in spreading good will and good service to all the people.

President.

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OUR LEGISLATIVE PROGRAM

Elsewhere in this issue we are giving in detail the legislative program adopted by the Council of the West Virginia State Medical Association. Every member of the profession in the state should familiarize himself with its details and then contact his representatives in the senate and house of delegates and ask their support in securing the enactment of the necessary legislation.

Section I is in general patterned after the laws of several other states notably Alabama, Georgia and Kentucky, in which the entire health and medical programs have been divorced from partisan politics and are directed by the state medical associations. The state health commissioner should be an individual with a highly developed training not only in medicine but especially in the science of sanitation and in the prevention of diseases, and certainly the Council of the State Medical Association can better evaluate the qualifications of a prospective appointee than can a layman. While membership on the public health council does not require as high a degree of training in preventive medicine as does the commissionership, the same principle of appointment logically applies here also. If the public health council is to direct the professional activities of the mental hospitals as is now the case with the tuberculosis sanitaria, it is proper that the panel of prospective superintendent appointees be presented by that body in the interest of harmonious administration.

The establishment of the Barboursville unit of the Weston State Hospital has been justified by the relief it has afforded the congestion in the mental hospitals of the state. However, from the standpoint of geographical location and in order to facilitate administration, it logically should become a part of the Huntington State Hospital.

The cancer control program in West Virginia, while pioneering and as yet only in swaddling clothes, has amply justified itself already and in order to function satisfactorily must have at least double the appropriation it now receives.

The arrangement with the Medical College of Virginia whereby that institution enrolls each session twenty students who have completed two years in medicine at West Virginia University is beyond the experimental stage and should be continued for another biennium. This pioneering cooperative venture between two states attracted much attention in the educational world when it was launched and has proven a definite success. We have information to the effect that Texas has made a similar arrangement with Howard University College of Medicine, Washington, D. C., and Meharry Medical College, Nashville, for the complete education of its qualified negro citizens who desire to undertake the study of medicine.

Proper housing of the two-year School of Medicine at Morgantown is a long-felt want. Certainly the request for one million dollars is well within reason and such an item in the University budget should be approved by the legislature.

The state health department's program is likewise meritorious and deserves enactment.

The great majority of West Virginia physicains already routinely do serological examinations on their pregnant patients. Justice to the prospective mother and her unborn babe demands that this test be done in all cases.

The crippled children's division logically belongs in the state health department, and the professional supervision of the state eleemosynary institutions should be under the public health council, but the fiscal affairs of these institutions should remain under the direction of the state board of control as at present.

The increase in the salary of the state health commissioner is imperative. The present arrangement is clumsy, the total pay is insufficient, and such a scheme is defensible only on the theory that the end justifies the means.

The present housing of the state health department is utterly inadeqate. Scattered as it is wherever space can be found hampers efficiency and renders administration difficult. Moreover, the volume of the work of health departments is on the increase now and will continue to grow with the coming years. Then, too, the state needs for other activities the space in the Capitol Building now occupied by the state health department. Certainly the request for an adequate building is within reason and the need is imperative. We trust the Legislature will look kindly and vote favorably upon this request.

We extend hearty congratulations to the profession of West Virginia upon its development of such a forward looking legislative program. Every item is amply justified and each, if enacted into law, will make our Mountain State a better place in which to live. It exults our soul to know that our doctors have at last awakened to the fact that they are not an isolated portion of the body politic, but that they constitute an active vibrant segement of the community in which they live and move. The program presented by the doctors is postwar planning at its best.

Good health is the greatest asset a state can have. The sooner the general populace awakens to the fact that health and medical activities constitute a large part of the problems confronting society and that the medical profession is the only segment of our population adequately equipped by education and training to direct these activities, the better and happier our citizenry will be.

Such a well intergrated and forward looking legislative program brings back to mind an outstanding paper presented many years ago before the conference of editors and secretaries by that scholarly medical philosopher of Wheeling, Harry M. Hall, the title of which was "Descartes Was Right." Dr. Hall sketched what he considered the ideal relationship between medicine and society and the obligations and functions of the medical profession in the modern democratic state, quoting as a text, so to speak, from the *Meditations* of the immortal French philosopher: "If ever the human race is lifted to its highest level intellectually, morally and physically, the medical profession will perform that service." All the learned professions should realize that one of their obligations as a profession is to endeavor to elevate the level of humanity culturally, morally and physically, and this duty is especially incumbent upon the healing professions, medicine, dentitstry, pharmacy and nursing. It is well then for our state and especially for our doctors that the organized medical profession has at last seen fit to blaze the trail for a healthier, happier and better West Virginia.

CHRISTMAS, 1944

The fourth Christmas after Pearl Harbor! Where we counted our military personnel overseas by the thousands in 1941, they represent us by the millions in 1944, fighting on every battle front that we may forever remain free.

It is not mere chance that our battle cas-

ualties have been the lowest in all wars. It is not just luck that the number of man days lost on account of illness is negligible compared with former wars. Nor did it just happen that we were able to place in the field the best conditioned fighting forces in the world. The medical profession more than anything else is responsible for the well being of the millions now serving our country. Over 50,000 doctors are with our troops the world over. These doctors will be found in the thickest of the fighting everywhere, with our sky-borne troops, tanks and artillery, in the jungles, on the desert, and in ships that sail the seven seas.

West Virginia has given more than four hundred doctors to the armed forces. Nearly sixty per cent of the total will be found overseas. In the letters they write back home they breathe optimism, determination to stick it out until the job is done. To these doctors we send a word of cordial greeting and sincere good wishes for the Holiday Season. There is a prayer in the hearts of all for the successful conclusion of hostilities and the safe return home of all our fighting forces, "in air, on land and sea."

Doctors are not forgotten on the home front. We wish for these members who are striving to maintain all the traditions of their profession in the face of the greatest of difficulties to carry on the fight and hold the line until their confrers return from the wars. A happy Christmas to all our members everywhere, and may the New Year bring continued blessings and courage to meet the challenge at home and abroad, and may there be peace throughout the world.

SPECIAL TREATMENT CENTERS

Ashford General Hospital at White Sulphur Springs and the Newton D. Baker General Hospital at Martinsburg have both been designated as special treatment centers for neurosurgery and neurology. In addition, Ashford has been designated for medicine and vascular diseases, and Baker for plastic and ophthalmologic surgery and psychiatry.

General News

LEGISLATIVE PROGRAM ADOPTED BY COUNCIL AND ASSOCIATION COMMITTEES

The joint meeting of the Fact Finding and Planning Committee and the Legislative Committee of the State Medical Association, held at Charleston, November 9, was attended by doctors from every section of the state. The Committee on Medical Education, and the Scientific Work Committee were also in session during the day. Members of the Public Health Council were guests at both the afternoon and evening sessions.

The meeting was arranged primarily for the purpose of considering a legislative program for 1945, and far-reaching proposals were agreed upon during the afternoon by the unanimous vote of the members of the two key committees. The report subsequently submitted to the Council by Dr. Ray M. Bobbitt, chairman of the Fact Finding and Planning committee, and Dr. R. O. Rogers, chairman of the Legislative Committee, at a dinner meeting at the Daniel Boone Hotel, was considered item by item and unanimously adopted in final form as follows:

I. Amend laws to provide for:

(a) The appointment by the governor of a state health commissioner from a list of three names or more to be submitted by the council of the West Virginia State Medical Association.

(b) The appointment of medical members of the public health council from a panel of three names for each position to be filled. to be submitted to the governor by the council of the West Virginia State Medical Association.

(c) The appointment of superintendents of state eleemosynary institutions from a list of names to be submitted to the governor by the public health council.

II. Reestablish the Barboursville unit of Weston State Hospital (mental) as a unit of the Huntington State Hospial.

III. Increase annual appropriation for cancer control from $50.000 to $100.000. (State health department budget.)

IV. Continue arrangement with the Medical College of Virginia for the enrollment of twenty students annually (each nine months under accelerated program) from the School of Medicine of West Virginia University. (This item included in the budget which will be submitted by West Virginia University.)

V. Establishment of a department of public health in connection with the School of Medicine at West Virginia University. (Item included in University budget for the second year of the biennium.

VI. The matter of drafting a bill to be introduced in the legislature at the regular session in January, 1945, covering the operation of hospital-medical-surgical service plans was left to the legislative committee, and it is understood that the committee will consult with similar committees from the hospitals and the hospital-medical service

LIBRARY OF THE COLLEGE OF PHYSICIANS

groups in an effort to reach an agreement on the provisions of the bill satisfactory to the members of all groups affected.

VII. The extension of Farm Security Administration medical-hospital service plans so as to provide service for certain families in the low-income group in every part of the state was approved in principle. (Several of such plans are now in operation in West Virginia.)

VIII. An appropriation of $1,000,000 for a new building for the two year School of Medicine at West Virginia University was recommended. (This item will be included in the University budget.)

IX. The council and both committees unanimously approved the following items in the state health department's legislative program:

(a) Prenatal serological examination for syphilis: (b) transfer of the crippled children's division from the DPA to the State Health Department; (c) transfer of supervision of the superintendents of state eleemosynary institutions from the board of control to the public health council; (d) creation of a dental hygiene division in the state health department; (e) increase of the state health commissioner's salary to $8,000 per annum; and (f) construction of a separate building on state-owned property near the Capitol to house all divisions of the state health department.

The council and both committees deferred action on approval of a proposed appropriation for the construction of a hospital in connection with the two-year School of Medicine at West Virginia University.

Besides the legislative program, several matters of importance were considered at the council meeting, at which Dr. R. J. Wilkinson presided as chairman.

Drs. C. L. Holland and J. M. Trach, of Fairmont, were elected to honorary life membership in the State Medical Association, and Dr. George W. Johnson, of McAlpin, already an honorary member, was nominated for affiliate fellowship in the American Medical Association.

The executive secretary reported that an additional dividend of twenty-five per cent had been declared by the receivers for Fidelity Assurance Association, and that a check for $1,026 had been received. An initial dividend of sixty per cent was declared last May, at which time a check for $3,488.40 was delivered to the Association.

The executive secretary also reported that the house owned by the Association, located at 2907 Noyes Avenue, Charleston, had been sold by the special committee appointed for the purpose for a consideration of $10,000, which net sum will be invested in U. S. Treasury bonds during the Sixth War Loan campaign. The life insurance policy owned by the Association was surrendered for cash in July, 1944, and the proceeds invested in U. S. Treasury bonds (Fifth War Loan). The committee appointed to handle these two matters is composed of Dr. W. E. Vest, chairman, and Drs. F. V. Langfitt, R. J. Reed, Jr., Thomas L. Harris, and W. A. McMillan.

Action on the endorsement of the legislative program of the West Virginia State Nurses' Association, providing for an all-nurse board of five registered nurses, with an advisory board of doctors, and at least two representatives from the West Virginia State Hospital Association, to serve as a licensing board for nurses, was deferred in order to give the members time to study the proposals.

The chairman requested the executive secretary to leave the room, and upon his return it was announced that the council had voted unanimously to increase the salary of the executive secretary by twenty-five dollars per month and the salary of the assistant secretary in the same amount.

Besides Dr. R. J. Wilkinson, chairman, the following members of the Council were present: Dr. Robert J. Reed, Jr., Wheeling, president; Drs. H. G. Steele, Bluefield, and Thomas G. Reed, Charleston, vice presidents; Dr. T. M. Barber, Charleston, treasurer; and Drs. R. O. Rogers, Bluefield; J. B. Clinton, Fairmont; R. D. Gill, Wheeling; Carl E. Johnson, Morgantown; Guy H. Michael, Parsons; E. A. Trinkle, Weston; James L. Wade, Parkersburg; Walter C. Swann, Huntington; N. H. Dyer, Bartley; Andrew E. Amick, Charleston; W. P. Bittinger, Summerlee; and Mr. Charles Lively, secretary ex officio.

The meetings were also attended by the following officers and councillors elect, members of committees and members of the Public Health Council: Dr. Thomas L. Harris, Parkersburg, president elect; and Drs. John P. Helmick, Fairmont; Curtis P. Artz, Grantsville; J. L. Patterson, Holden; Ray M. Bobbitt, Huntington; D. A. MacGregor, Wheeling; G. G. Irwin, Charleston; George P. Evans, Iaeger; George P. Grisinger, Charleston; Walter E. Vest, Huntington; B. H. Swint, Charleston; W. C. D. McCuskey, Wheeling; J. E. Offner, State Health Commissioner, Charleston; and E. J. Van Liere, Dean of the School of Medicine at West Virginia University.

ELKINS DOCTOR HONORED

Dr. Benjamin I. Golden, of Elkins, was elected treasurer of the United States chapter of the International College of Surgeons at the annual meeting held in Philadelphia early in October.

WEST VIRGINIA DOCTORS HONORED AT ANNUAL SMA MEETING AT ST. LOUIS

The 38th annual meeting of the Southern Medical Association held at St. Louis, November 13-16, 1944, was attended by doctors from practically every part of West Virginia. Full scientific sessions were presented each day, but all formal entertainment, including the customary presidential reception and ball, was dispensed with on account of war conditions.

Dr. James A. Ryan, of Covington, Kentucky, who succeeded to the presidency upon the death last spring of Dr. W. T. Wooten, of Hot Springs National Park, Arkansas, presided at the general sessions. Dr. Edgar G. Ballenger, of Atlanta, Georgia, succeeds Doctor Ryan. The new president-elect is Dr. M. Y. Dabney, of Birmingham, Alabama, editor of the Southern Medical Journal.

Two West Virginia doctors were honored at the meeting, Dr. R. J. Wilkinson, of Huntington, chairman of the Council of the State Medical Association, was elected secretary of the section on surgery. Dr. Walter E. Vest, who served as president of the Southern Medical Association in 1939, was elevated to the Chairmanship of the Board of Trustees. Another Huntington doctor, Ray M. Bobbitt, is a member of the Council.

Dr. Charles E. Smith, of Terra Alta, is the retiring vice chairman of the section on general practice. Dr. C. F. McClintic, of Williamsburg, former state health commissioner, presided at the sessions of the Southern Branch of the American Public Health Association of which he has been president for two years.

At the general session held November 14, Dr. McClintic spoke on the subject of "Mental Hygiene as Part of the Public Health Program: Its implications." Mrs. Laurene C. Fisher, director of the bureau of public health nursing of the state health department, presided as chairman at the meeting of the public health nursing section.

In the surgical specialties section of the scientific exhibit, Dr. A. P. Hudgins, of Charleston, presented an exhibit on "Technique Using New Cannula for Hysterosalpingography."

The annual session of the Woman's Auxiliary was ommitted due to the decision of the executive committee of the Council that the meeting at St. Louis should be limited strictly to scientific activities. Mrs. John P. Helmick, of Fairmont, president of the Auxiliary to the Southern Medical Association, will hold over for another year. She attended the meeting at St. Louis.

The following West Virginia doctors were registered up until Wednesday evening, November 15:

Andrew E. Amick, Charleston; R. L. Anderson, Charleston; Jerome C. Arnett, Rowlesburg; Major Lloyd R. Ayers (MC); R. M. Bobbitt, Huntington; N. F. Boland, Williamson; James M. Bonnar, Fairmont; R. S. Coffindaffer, Shinnston; Hokie H. Fisher, Dunbar; Laco W. Gochenour, Clarksburg; Herbert H. Haynes, Clarksburg; Norris F. Hines, Huntington; Archibald P. Hudgins, Charleston; William K. Mackey, Huntington; George R. Miller, Fairmont; T. W. Moore, Huntington; Hu Crim Myers, Philippi.

William Thomas McClellan, Ethel; Clifton F. McClintic, Williamsburg; Ulysses G. McClure, Charleston; Thomas W. Nale, South Charleston; Leonard E. Neal, Clarksburg; J. E. Offner, Charleston; Wellington H. Parker, Braeholm; Cecil Omar Post, Clarksburg; C. N. Slater, Clarksburg; Charles Earl Smith, Terra Alta; H. V. Thomas, Clarksburg; J. M. Trach, Fairmont; Walter E. Vest, Huntington; Capt. Walter E. Vest, Jr. (MC); Robert S. White, West Union; R. J. Wilkinson, Huntington; and Joe Yost, Fairmont.

RELOCATIONS

Dr. D. M. Ryan, of Hinton, and Dr. J. N. Reeves, of Oak Hill, have located at Charleston.

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Dr. H. R. DuPuy, formerly of Martinsburg, is now engaged in general practice at Winchester, Virginia.

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Dr. W. E. Bundy, of Minden, who has been in industrial practice for the New River and Pocahontas Coal Company for the past 27 years, has moved to Oak Hill, where he will engage in private practice.

* * * *

Dr. C. G. Stroud, of Brownton, has moved to Shinnston.

PHC TO MEET IN FEBRUARY

The next regular meeting of the Public Health council will be held February 26-28, 1945 at the Daniel Boone Hotel, Charleston, for the purpose of examining applicants for licensure in this state.

DISCUSS WORK OF WASHINGTON BUREAU AT FIRST REGIONAL MEETING

The first of a series of regional meetings held under the auspices of the Council on Medical Service and Public Relations of the Ameircan Medical Association attracted a large group of A.M.A. delegates, officers and councillors and heads of key committees of state medical associations in Kentucky, West Virginia, Ohio and Indiana. The meeting was held at Cincinnati, Sunday, October 29, at the Netherland Plaza Hotel. Besides officers of the Council, several members of the A.M.A. board of trustees were present and discussed problems confronting that body at the present time, particularly with reference to the work at Washington.

Mr. J. W. Holloway, director of the bureau of legal medicine and legislation, who has been acting secretary of the council since the resignation of Dr. Lombard Kelly, discussed the duties of the members of the council as fixed by the board of trustees, and reviewed the work that has already been done. Dr. E. J. McCormick, presided as chairman, and Dr. Joseph Lawrence, who is in charge of the Washington office, discussed every phase of the work that is being done there.

The process of the establishment of medical-surgical service plans in the four-state area was discussed at a roundtable session in the afternoon. Dr. Ray M. Bobbitt, chairman of the fact finding and planning committee of the West Virginia State Medical Association, reported for West Virginia. It will be remembered that this committee prepared a basic contract for use by component medical societies in establishing plans in local communities.

Dr. James R. Bloss, member of the board of trustees, spoke concerning the desire of the board to do everything possible to add to the success of the work of the new council, particularly the part that is being played by the new office that has been established in Washington.

The meeting was attended by the following representatives from West Virginia: Dr. T. L. Harris, president-elect, Dr. Ray M. Bobbitt, chairman of the fact finding and planning committee; Dr. R. O. Rogers, chairman of the Legislative committee; Dr. R. J. Wilkinson, chairman of the council; Dr. W. E. Vest, A.M.A. delegate and editor of The Journal; Dr. James R. Bloss, member of the board of trustees, and Mr. Charles Lively, executive secretary of the State Medical Association.

MILK PRODUCTION IN WEST VIRGINIA

Production of milk in West Virginia reached the total of 371,000,000 quarts in 1943, according to "Wartime Milk Facts," printed and distributed by the Milk Industry Foundation. The average production per cow was 1600 quarts during the same year.

In this state, 2,577,000 pounds of creamery butter were produced. Cheddar cheese production amounted to 153,000 pounds. The production of ice cream in that year totalled 4,003,000 gallons. Cash income from milk produced in West Virginia in 1943 reached the total of $15,681,000.

The Foundation is authority for the statement that a quart of milk—4 glasses—supplies approximately these percentages of the daily nutritive requirements of an average adult; Calcium 100%, vitamin G 78%, phosphorus 69%, protein 46%, vitamin A 37% niacin 30%, vitamin B¹28%, iron 16%, and vitamin C 7%.

COMMITTEE ON SCIENTIFIC EXHIBIT

Dr. Thomas L. Harris, president elect of the State Medical Association, has announced the appointment of Drs. John P. Helmick, of Fairmont, and Fred R. Whittlesey, of Morgantown, as members of the committee on scientific exhibit in connection with the annual meeting at Clarksburg in May, 1945. Dr. Hu C. Myers, of Philippi, was named chairman of the committee several weeks ago.

SPECIAL ASSESSMENT

The special assessment of $5.00 per member for 1945, levied by the unanimous vote of the House of Delegates at the annual meeting at Wheeling last May, will be payable along with the regular State Medical Association dues on January first. The assessment should be paid to secretaries or treasurers of component societies, to be remitted to the Association with the regular dues of $10.00 per member.

Membership cards and certificates and a special receipt will be mailed to members promptly as dues and assessments are transmitted by component societies to the headquarters office.

SECRETARIES AND EDITORS CONCLUDE SUCCESSFUL CONCLAVE AT CHICAGO

The annual conference of secretaries of state medical associations and editors of journals, at Chicago, November 17-18, was in point of interest and attendance one of the most successful ever conducted during the many years such gatherings have been sponsored by the board of trustees of the American Medical Association. Editors, secretaries, and other officers of state medical associations joined officials of the AMA in discussing freely the problems of the medical profession.

In calling the meeting to order, Dr. James R. Bloss, of Huntington, member of the board of Trustees, spoke on the importance of educating our own doctors to the need for reading their state medical journals and the *Journal of the American Medical Association.* Dr. Douglas L. Cannon, secretary of the Medical Association of the State of Alabama, was named as chairman of the conference and presided throughout the two-day session.

Need for Educational Programs

The importance of making known to the people of this country what the profession has done and is doing to help them get well, keep well, and live a long life was stressed by Dr. Herman L. Kretschmer, of Chicago, president of the AMA. "Great strides have been made in the treatment of children's diseases," he said, "and we are now doing great things medically for the care and treatment of the aged, and individual educational programs by the state medical journals would help considerably in this campaign."

Dr. Roger I. Lee, of Boston, president-elect of the AMA quoted the surgeon general of the army as saying that medical officers will of necessity be kept in the service for some time after the war on the western front is over. If universal military training is adopted then many thousands of doctors will be on duty with our armed forces.

Medical Care

Dr. Robert E. S. Young, of Columbus, stated that, while there is no plan that as a whole includes the very low income group or indigents, probably half the people of the country are now covered by some form of pre-payment medical service, industrial insurance and list practice included.

"The objective of the American Medical Association is to provide medical care of a high character for every person in the United States," said John L. Fitzgibbon, chairman of the council on medical service and public relations. "No plan for such care can succeed," he said, "without the hearty cooperation of the profession." He expressed it as his opinion that the drafting of medical students might have been made necessary on account of the high rate of rejections for military service.

Dr. E. D. Plass, of the College of Medicine, State University of Iowa, placed the blame directly on congress for the method of operation of the EMIC program, and not on the Children's Bureau, which he believes is undoubtedly carrying out the mandate of congress.

National Fitness Program

The proposed national fitness program was ably discussed by Dr. J. W. Wilce, of Ohio State University, and Dr. Morris Fishbein, editor of the Journal of the American Medical Association. The latter stated that if the program is to be adopted on a nationwide basis, the doctors will have to play a prominent part in it. Dr. Olin West, secretary of the AMA, said that the movement to be successful must be carried even into the rural communities.

The conference endorsed the proposed physical fitness program to the extent of requesting all the doctors present to try to interest the members of their profession back home in this important work.

The conference also went on record as favoring the operation of blood banks after the war for the protection of the civilian population.

1945 AMA MEETING IN PHILADELPHIA

According to an announcement printed in the November 25 issue of *The Journal of the American Medical Association*, the 1945 meeting of the American Medical Association will be held in Philadelphia, June 18-22, unless war conditions prevent. The meeting was to have been held in New York a week earlier, but investigations recently made clearly indicated that the necessary facilities would not be available in that city because of the war emergency.

NAMED PART-TIME HEALTH OFFICERS

Dr. Allen E. LeHew, of Lewisburg, and Dr. J. R. Richardson, of Union, have been appointed part-time health officers for Greenbrier and Monroe counties respectively, succeeding Dr. Herbert E. Duncan, former district health officer, who is now in Nashville, Tennessee.

WITH DOCTORS IN THE SERVICE

Writing from somewhere "along the Ledo road in Burma," Capt. Joseph T. Peters, of South Charleston, reports a trip through a game preserve in Assam. "This trip," he says, "lasted three hours, and we went through elephant grass almost as high as the elephant's back.

"I was able to get a picture of rhinos at 20 feet. We saw eight rhinos, a few deer, but no cats, as the area was rather wet at the time.

"Since being on foreign service I have seen a bit of Africa, have crossed India, and have visited most of Bengal and Assam. Our hospital takes care of American and Chinese soldiers. While I find my work most interesting, I would much rather be back in the good old Kanawha Valley.

"I have visited with Major R. A. Updike, Major A. C. Chandler, and Capt. John W. Hash since I have been in this neck of the woods. It was mighty nice to run into old friends. These are the only boys I have seen since coming to India. Best regards to all the West Virginia "Docs."

Captain Josept T. Peters, with native bearers in Assam

Commander Vincent T. Churchman (MC), USNR, of Charleston, who recently returned to this country from overseas duty, is now assigned to the U. S. Naval Academy, at Annapolis, Maryland.

Captain James L. Hager, of Charleston, has been transferred from a station hospital in New Guinea to a base in the Netherland East Indies. He reports that the country there is more beautiful than in New Guinea referring especially to the coral reefs and swaying palms.

Captain Hager is serving as medical inspector at the base and writes that the work is very interesting. "In setting up in the jungle land," he writes, "the health of the command depends on safe and adequate water supply and sanitary control. The breeding of insects and rodents and the transmission of diseases are in direct proportion to the disposition of our wastes, and the purification of water.

Captain Hager is also serving as mess supervisor for the medical units. He is charged with the selectoin and preparation of foods, and says that he has been surprised to learn the many angles involved in the procurement and preparation of a good mess.

"I have been out here for two and a half years," he says, "and as I am now in a new campaign I may not get rotated back to the good old United States for another six months. I am anxious to take my turn."

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Capt. Golf P. Lilly, of Charleston, who has been stationed at Warrenton, Virginia, is now assigned to the Stark General Hospital at Charleston, South Carolina.

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Capt. John C. Brick, of Charleston, who has been assigned to the Redistribution Station, Army Ground and Service Forces at Miami, Florida, has been transferred to the 136th Evacuation Hospital at Ft. Jackson, South Carolina.

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Capt. James E. Wilson, Jr., of Clarksburg, has been transferred from Torney General Hospital at Palm Springs to the Pasadena Area Station Hospital at Pasadena, California.

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Lt. Robert G. Smith, of Beckley, is assigned to the Percy Jones General Hospital at Battle Creek, Michigan.

Capt. Dan Glassman, of Charleston, who has been stationed at the A. P. Hill Military Reservation, is now assigned to a Station Hospital somewhere in the Pacific.

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Capt. LeRoy B. Matthews, of Charleston, is with an Air Depot Group operating in the Pacific.

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Lt. F. C. Amick, of Charleston, who has been at a parachute school at Ft. Benning, Georgia, is now assigned to the 673rd F. A. Bn. at Camp Gordon, Georgia.

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"After the heat of central and east Africa, the sands of the Lybian desert, and the cold and rain of Corsica and 'sunny' Italy, the mountains of West Virginia look like the Promised Land to me," writes Major Franklin H. Goodwin, of Welch, who is now at Ashford General Hospital, at White Sulphur Springs.

"During the twenty-six months that I spent overseas," he writes, "I often thought 'this is one of the things I want to remember to tell when I get back home.' However, now that I have been back for a few weeks, the memories of the hardships, the incidents that assumed such magnitude at the time have faded and almost all that remains is the memory of the good fellowship, the team work and the determination that we would not let the fighting man down. It was a great experience, but I am glad to be back in this country now and hope that I may be able to stay for a few months anyway. I wish to express my appreciation for the copies of The Journal, often months late in reaching me, but always most welcome."

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Capt. Thomas L. Woodford, of Belington, is Battalion Surgeon for a field artillery battalion operating somewhere in France. "It has been a pleasure to look after a number of French civilians from time to time," he writes. "Most common ailment is impetigo. I shall use neither the space nor take the time to describe the ups and downs of a medic in combat. Just read the articles written by the various war correspondents."

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Major L. E. Dunman, of Gary, writes from France to express his appreciation for copies of the Journal sent to him there. He is acting chief of medical service at a general hospital. Before going overseas, he was in charge of the gastro-intestinal service at a Station Hospital at Camp Davis, North Carolina, for over three years.

In his letter, dated October 11, he says that his hospital is being set up in tents and that he expects to be operating in a couple of weeks. "We have seen considerable evidence of fighting in our present location," he writes, "and I can assure you that our boys have not been on a picnic. It will all make good material for a bull session when we get back home."

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After spending nineteen months in Africa, Italy and the Mediterranean theater, Lieut. Edward S. Phillips (MC) USNR, of Wheeling, is now assigned to the National Naval Medical Center at Bethesda, Maryland. At present he is doing plastic reconstruction surgery. He has this to say of his return trip:

"After a most enjoyable flight home down the African coast, across the South Atlantic to Brazil,

ADDRESSES WANTED

Information is desired concerning the present addresses of the following members of the West Virginia State Medical Association now in the military service:

Ashman, Hyman, Gallagher
Ashworth, Harold, Moundsville
Bateman, George, Williamstown
Booher, W. T., Wellsburg
Butterfield, D. L., Milburn
Cardey, N. L., Winona
Cunningham, G. R., Killarney
Davis, W. W., Beckley
Holmes, E. B., Parkersburg
Jones, C. T., Pemberton
Laslie, J. C., Charleston
Moore, Moore, Jr., Beckley
Nutter, P. D., Beckley
Prioletti, Vincent, Weirton
Thomas, W. C., Charleston
Vaughn, P. E., Beckley
Ward, Harold W., Sutton
Wood, Edward W., Beckley
Woolwine, J. H., Tams

Please mail information concerning any of the doctors whose names appear on this list to The West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia.

and then up the coast to South America and through the Caribbean Sea, the man-made forest of steel, brick and mortar that is New York looked wonderful to us. It is great to be back in the United States."

Lieut. Phillips says that he had a nice visit at Casablanca with Lt. W. E. McIlvain (MC), USNR, of Moundsville, who had been transferred there after taking part in the Anzio expedition.

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"My hospital has been trying to keep up with General Patton in the present cross-country race," writes Captain John C. Condry, formerly of Charleston, from somewhere in France. "We have had plenty of work to do here, but it doesn't take the Army long to get out of sight, and we spend at least half of our time moving to new locations. We passed Paris so fast that none of us so much as got to look at the city. Maybe we'll catch it on the return trip." Captain Condry says that due to the many moves that are being made by his hospital, he has received very little mail and has had time to write but few letters.

* * * *

We have just heard from Commander Henry J. Wiser (MC), USNR, of Bluefield, who is stationed on a U. S. hospital ship, operating in the Southwest Pacific. He tells about the work of Navy doctors in that sector and reminds the doctors back home that a tremendous task lies before them in the mental and physical rehabilitation of our fighting men. His letter follows:

October 13, 1944.

Dear Mr. Lively:

Your letter of September 12th received a few days ago. It will certainly be a pleasure to receive the Journal. Thank you very much for your trouble.

After being at the Naval Academy for two years, I was assigned to a hospital ship operating in the Pacific. The work has been very interesting and at times a little rugged. We are fortunate in being in a position to get the casualties first hand from the beach. Our patients are practically all stretcher cases which keeps all hands plenty busy. The problem for the first few hours is to decide which ones we can safely put off for twenty-four or forty-eight hours. Experience has proven that our decisions are not always correct. On each trip we believe we profit from our experiences on previous ones.

We have well-trained shock teams which are really doing a marvelous job. These units consist of nurses and corpsmen supervised by a physician.

Compound fractures of course are the rule. Out of over two thousand patients we have seen possibly three simple fractures. Chest and belly wounds are handled as soon as possible. Most of these cases are in considerable shock and careful selection for surgery is a major problem. The facial, neck and eye cases present conditions we very seldom encounter in civilian life. Complete loss of substance and deeply imbedded foreign bodies very often tax our ingenuity. When we have a load, we could easily use a hundred doctors. Our complement is fifteen.

So far we have been in on the show at Saipan, Tinian, Guam and Palau. Where we go from here nobody knows.

Our casualties are kept aboard for a week or ten days enroute to a forward hospital base.

Medicine aboard a hospital ship, as you probably have gathered from this very inadequate account, is primarily lifesaving. The medical profession I am sure is well aware of the tremendous task ahead in the mental and physical reconstruction of these boys. We all hope and pray that we will be in a position which best suits the medical profession and the patient to care adequately for the boys who are doing such a grand job.

Best wishes to all my friends. Thank you again for remembering me.

Sincerely yours,

Henry J. Wiser.

* * * *

According to a letter received from Lieut. Nancy Kiess, ANC, Lt. Col. Everett McCauley is chief of surgery in the hospital to which she is assigned. Col. McCauley was formerly located at Rainelle, and has been in the military service since 1942.

Lieut. Kiess states that she read a copy of The West Virginia Medical Journal following the battle of Carenton. The evacuation hospital was set up within two miles of the front lines at that time.

"In the first forty-eight hours we were operating at Carenton," she writes, "we had 500 admissions. We operate in tents and move on a day's notice. In plain words, we evacuate our patients and pack our tents and travel. Our record for one day is 107 operations within twelve hours. You could not imagine moving a hospital of our size at home in the same manner, but I guess there is magic in the world. Everything is just like clock work, and we move and set up in a couple of hours."

Lieut. Kiess is assistant to the operating room supervisor of her evacuation hospital. She is a West Virginian.

* * * *

From France comes this letter from Captain Leonard Eckman, of South Charleston, in which conditions in that country after the German withdrawal are vividly described:

France, 25 Sept. 1944

My dear Mr. Lively:

Since my last letter I haven't received any copy of the Journal, but that's not unusual because our mail varies from droughts to deluges depending on how often we move. The battalion has moved quite a bit and we've seen a lot of France. Censorship forbids my describing the damage too explicitly but some of the places that were the scenes of hard fighting really took a beating. We passed through cities that were completely wrecked, with just walls standing here and there, and debris lining the

sides of the road six to ten feet high, and refugees returning, most of them on foot, pushing or pulling carts piled high with their belongings.

They go in big for bicycles here, even more than in England, and have special trailers for the bikes. The greater part of the automobiles and trucks run on charcoal, and they are usually piled high with people, household goods, and bicycles. I think that the German vehicles that have been captured intact are turned over to the FFI, and you can see these guys running around everywhere, armed to the teeth. All along the roads are wrecked German vehicles and tanks, most of them burned out, with all wheeled vehicles stripped of their tires. Surprisingly, the roads remain in good shape.

Most of the places we've seen in France have either been untouched or hardly damaged at all. Some places have electricity and running water and look quite normal, except for American MPs and lots of French uniforms and civilians wearing FFI arm bands. The French tricolor plus the Cross of Lorraine is universal. Wherever we go the people wave and the kids give us the V-salute. The people are quite well dressed, or at least well groomed. In the cities, we see leather shoes, but they cost $60.00 on the black market. So usually the shoes are made of canvas or leather uppers with wooden soles. Farmers and sailors working on the inland canal boats wear wooden sabots, big clumsy affairs that really clump along on a hard road.

There seems to be enough food, more now that the Germans have left. But from what I have seen, there are no signs of malnutrition among the people, and I've looked at quite a few youngsters, even examining their teeth. One thing is universal, and that's the French bread. It is rationed, but there seems to be plenty of it,—tremendously long thin brown loaves. You see it all over, and it tastes good. The French have had no white bread for over four years, and when I gave a mother some for her sick baby, she started to cry.

The French tobacco is rationed, odorless, and looks like dried cord. They like our cigarettes and will swap eggs and fruits for them if they can't talk us out of them. They also like our soap and candy. I've treated more than one kid who had a stomachache from too many "bonbons."

In Paris, I understand the French people have been offering as much as $20 for a carton of cigarettes, but trade like that is discouraged by the Army, to put it mildly.

My outfit lives in whatever facilities we can find. Last week we were bivouacked in pup tents alongside a canal filled with stranded canal boats, some strafed and burned, some with families living on them. The system of dams and locks has been out of order for four months so the barges are simply groun'ed. Some of the families on them are quite trashy, dirty and odoriferous, and make no effort to help themselves. Others keep their boats in good shape, raise rabbits and poultry, and make the best of a bad situation.

The ground along the canal was hard chalk and to dig our tents in was really quite an undertaking. One old bargeman brought me a big pick and shovel and helped me dig and fill sandbags and was extremely grateful when I gave him a cigar, his first in five years. On the whole, the civilians in this area plagued us incessantly. We were the first American soldiers they'd seen at close range. And they certainly made the range close enough. They wandered all over camp all ages and sizes, staring at us for a half hour at a time. Our kitchen and mess line was extremely popular.

I spoke to quite a few young men who were members of the FFI. They wore German boots, obtained from Germans they had killed. They said that quite a few of the FFI were Czech and Polish soldiers, forced into the German Army, trained as paratroopers, who jumped from their planes and deserted to the FFI shortly after D-Day.

Our present area is pleasant for two reasons. One is that there are acres and acres of vineyards around and champaigne is available and cheap. We buy it from $1.40 to $3.00 a bottle, vintage 1934, 1937, and 1940. At cafes it's more expensive, but we buy it from the bottling plants. No ice buckets, no white napkins, no champagne glasses,—only canteen cups and champagne. In another part of France we found Calvados, a drink so powerful it almost dissolves gold inlays. I think it's about 140 proof. Nobody liked it.

The other reason is that once again we're under roofs. We're living for the time being in really fine dormitories built by the French and used by the Germans for the past four years as a tank school for non-coms. The barracks show plenty of traces of Germans, who apparently cleared out in a hurry. They didn't even booby-trap or mine the place.

It seems kind of funny wandering through the rooms only recently vacated by the Germans. The names of the former occupants are still posted on the doors. In the corridors the rifle racks have the names on them. So do the wooden lockers, which we're now using. The ceilings are over 15 feet high and the walls are covered with sketches and paintings, some of which are remarkably fine. They show various phases of military life, and scenes from Germany. Surprisingly enough, there are practically no swastikas evident and only one picture of Adolph. Another thing I was surprised to see was a sign announcing both Catholic and Evangelistic religious services. In the officers' building there was a barbershop with fancy chairs, basins, mirrors, and chrome fixtures. From the signs on the walls and the hundreds of empty bottles we found downstairs, the Nazi officers must have gone in pretty heavily for cologne and smelly shampoos and perfumes. They cut a lot of firewood which is coming in quite handy with the weather cooling off.

Well, I guess this letter is too long. It's taken odd moments all day to write it. Tomorrow I'll be out all day riding.

Sincerely,

Leonard M. Eckmann.

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The part the "Seebees" are playing in the war is vividly described in the following letter received from Commander C. E. Lewis (MC), USNR, of Charleston, from somewhere in the Marianas:

September 30, 1944.

My dear Mr. Lively:

Received your letter of September 12, and appreciated it very much, and thank you for sending me The Journal. I should have given you my forwarding address when I left for the navy.

I left Charleston on August 15, 1942, and was assigned to duty at the Navy Yard Dispensary, Washington, D. C. I had just one month at this activity when I was further assigned to N. O. B., Norfolk, Va. for training with a construction battalion for duty outside the continental limits. The Battalion had more training at Gulfport, Miss., and at Port Hueneme, California. We had 15 months on one of the Hawaiian Islands constructing Naval air stations, and from there on to the Mariana Islands.

Our duty in the Hawaiian Islands was very pleasant. We were assigned to a new Naval Air Station Dispensary (in reality a 50-bed hospital) where the duty was quite interesting and gainful. The climate was marvelous. Every day was a summer day, but not real hot and sticky. The volcanic mountains, plantations, and flowers were beautiful the year round.

We left the Hawaiian Islands early this past summer and headed west. After several weeks at sea we arrived at one of the Mariana Islands (for security reasons we are

not permitted to mention which one) and we were certainly glad to sight land once more. There was plenty of fireworks going on. From the deck about 0400 it looked like a fourth of July celebration and was truly very beautiful.

This island sure was a mess. As yet I have not seen a house or building in the small towns that has not been almost completely demolished.

We had rather tough going for several weeks. We lived in a bivouac camp (pup tents and k-rations) and waded around in mud and rain. Our first job was to bury a great many of the enemy dead, and the stench was terriffic. A few complained, but all I had to do was remind them what the Marines ahead of us had gone through with and there was no more "bitching." We are now in our permanent camp and things are coming along swell.

The "Seabees" have done and are doing a swell job. They unquestionally will come in for a great deal of the glory for their part when final and total victory comes. Personally I am very proud to say that I have been a part of the organization.

I expect to receive my orders from the Bureau of Medicine and Surgery for a change of duty in the next few months and a much needed 30-day leave to see what's going on in the old home town.

Very sincerely yours,

C. E. Lewis.

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Capt. Vincent Prioletti, of Weirton, who has been with a station hospital at Camp Van Dorn, Mississippi for over a year, is now with our armed forces in France. He writes that he recently visited Paris, which he thinks is one of the most beautiful cities in the world.

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Capt. Robert M. Ferrell, of Webster Springs, who had been in Italy for several months, is attached to a headquarters company, which landed

Capt. R. M. Ferrell, with shell casing used in the German gun, "Anzio Express."

in Southern France on D-day. His old outfit, veterans of Salerno and Anzio, accompanied him. "It was a walk-away," he writes, "compared with the other amphibious operations. Anything compared with Anzio seems relatively quiet!" Continuing Captain Ferrell writes:

"From Salerno, our outfit, a medical battalion, supported three veteran divisions to the Venafro-Cassino sector, and was then withdrawn, along with the division from the Anzio-Nettino end run. We were the beach casualty clearing company there. I am enclosing snapshot of shell from the German gun, the 'Anzio Express,' that shelled us at that beach head. The gun was captured north of Rome.

"At Anzio we ran a venereal hospital using penicillin for the first time in that sector for treatment on a large scale. I was also one of the instructors in the malaria conrol school. For diversion, I spent a couple of weeks with a field artillery howitzer unit. The invasion of France was well executed, and the raapid advance was very gratifying to us after being stalemated so long at Anzio. At the present time, I am hoping it will soon be, 'somewhere in Germany.'

"I was very sorry to hear of the death of Dr. Norval Carter, of Huntington. His volunteering for combat duty was in keeping with his personality.

"The Journal continues to improve in my estimation. I have had several medical officers from other states comment favorably on it. Please give my regards to all my friends back home."

Obituaries

RICHARD VANCE LYNCH, M.D.

Dr. Richard Vance Lynch, of Clarksburg, died at his home in that city Monday night, November 13, at the age of 60 years, following a heart attack.

Doctor Lynch was born at West Milford and attended school at Fairmont State Normal and West Virginia University. He received his medical degree in 1910 from the Cincinnati Medical College, Cincinnati, Ohio. He served an internship at Seton Hospital, Cincinnati, and when he located in West Virginia for the practice of medicine he became company physician for the Hutchinson Coal Company at Erie. At the time of his death he was serving as physician for the Graselli Chemical Company at Spelter.

In 1912, Doctor Lynch was married to Mary Romine, who survives. He is also survived by a son, Lt. Richard V. Lynch, who is stationed at Carlisle Barracks, Pa., and one sister, Mrs. B. F. Bowman, of Clarksburg. He had been a member of the State Medical Association since 1912, and served as president of the Harrison County Medical Society in 1942. He was a Thirty-second degree Mason, Knights Templar, and member of the Clarksburg Lodge of Elks.

County Society News

CABELL

A symposium on cancer was held by the Cabell County Medical Society at the regular monthly meeting at the Prichard Hotel, Huntington, November 9. Dr. Paul R. Gerhardt, of Charleston, director of the division of cancer control, and Dr. Siegfried Werthammer, of St. Mary's Hospital, Huntington, were the guest speakers. A number of interesting museum specimens were displayed at the meeting.

COLE D. GENGE, *M.D.*,
Secretary.

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HARRISON

Dr. Paul R. Gerhardt, director of the Division of Cancer Control in the State Health Department, was the guest speaker at the regular monthly meeting of the Harrison County Medical Society, held at the Stonewall Jackson Hotel, Clarksburg, November 2. He explained in detail the set-up of the Cancer Control Division in West Virginia.

JOHN C. KERR, M. D.
Secretary.

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KANAWHA

A symposium on industrial medicine was conducted by Kanawha Medical Society at the regular meeting held at the Daniel Boone hotel, Charleston, November 21. The following program was presented:

"Examination for Employment in an Industrial Plant."—Dr. J. H. Thornbury, of duPont, Belle.

"Relationship of Industrial Conditions to the General Practitioner."—Dr. C. N. Scott, of American Viscose, Nitro.

"Medical Precautions and Treatments Associated with the Chemical Industry."—Dr. T. W. Nale, Carbide and Carbon Chemicals Corporation, South Charleston.

"Foreign Bodies in the Eye."—Dr. Ralph S. McLaughlin, Charleston.

"Health Service for Industrial Workers."—Dr. C. S. McKinley, Director of the Bureau of Industrial Hygiene.

The following officers were elected for 1945: Dr. R. L. Anderson, president; Dr. George F. Grisinger, vice president; Dr. Thomas W. Nale, board of censors. The term of the secretary, Dr. W. Paul Elkin, will not expire until 1946.

W. PAUL ELKIN, M.D.,
Secretary.

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LOGAN

Dr. Paul R. Gerhardt, director of the Division of Cancer Control, and Dr. J. Ross Hunter. of Charleston, were the guest speakers at a meeting of the Logan County Medical Society held at the Aracoma Hotel, Logan, October 12. Dr. Gerhardt spoke on the cancer control program in West Virginia and Dr. Hunter discussed treatment of cancer, with especial emphasis on cancer of the cervix.

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A joint dinner meeting of the Logan County Medical and Dental societies was held at the Rainbow Gril, November 9, following which a scienific program was conducted at the Aracoma Hotel.

Dr. Ralph S. McLaughlin and Dr. Cecil R. Adams, D.D.S., of Charleston, were the guest speakers. The program concerned focal infections, with special reference to the teeth. Dr. Adams demonstrated the dental aspects of the subject, and Dr. McLaughlin the medical, presenting a series of x-rays.

At the business meeting, Dr. B. R. Gibson, of Omar, was accepted as a member by transfer from Mingo County.

C. L. BROWN, M.D.,
Secretary.

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MERCER

Major E. N. Pleasants and Major F. H. Goodwin, who are on the staff of the Ashford General Hospital, White Sulphur Springs, were the guest speakers at the regular monthly meeting of the Mercer County Medical Society, held November 16, at the Memorial Building in Princeton.

Major Pleasants, discussing neuropsychiatric problems, stated that there has been a great increase in such cases during the present war. He discussed at length the attitude that should be taken towards the returning service men, suggesting that they should be treated as civilians and not as ex-soldiers, and that no discussion of their experiences should be initiated by the civilians.

Major Goodwin, of Welch, who has had two years' service in the near East, Africa, Sicily and

Corsica, spoke on the development of field hospitals. Both papers were discussed by several members of the society.

At a short business meeting held after the scientific session, the president, Dr. Harry G. Steele, appointed Drs. J. R. Shanklin, C. J. Reynolds, and Ben. W. Bird, Jr., as members of the refreshment committee for the annual banquet. He also named a legislative committee which is composed of Drs. Frank J. Holroyd, C. J. Reynolds, and E. W. Horton.

Following the meeting, the members were served a buffet supper at the home of the secretary.

FRANK J. HOLROYD, M. D.,
Secretary.

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PARKERSBURG ACADEMY

At the regular monthly meeting of the Academy of Medicine of Parkersburg, held October 11, 1944, at St. Joseph's Hospital, Parkersburg, Dr. Paul R. Gerhardt director of the Division of Cancer Control, spoke on cancer control in West Virginia. Mr. Charles Lively, Executive Secretary of the State Medical Association, was also present and discussed the proposed legislative program of the association.

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Dr. C. Scott McKinley, director of the Bureau of Industrial Hygiene, State Health Department, was the guest speaker at the meeting of the Acad- of Medicine of Parkersburg, held November 1. His subject was "Industrial Health."

W. F. ROGERS, M.D.,
Secretary.

CHANGES AT SCHOOL OF MEDICINE

David F. Marsh, Ph.D., assistant professor of pharmacology at the University of Georgia School of Medicine, Augusta, has accepted appointment as associate professor of pharmacology and head of the department at the School of Medicine at West Virginia University, Morgantown, Succeeding George A. Emerson, Ph.D., who has accepted a similar appointment at the University of Texas Medical Branch, at Galveston. The appointment is effective January 1, 1945. J. K. Finnegan, Ph.D., instructor in pharmacology has resigned to accept a similar appointment at the Medical College of Virginia, at Richmond. He is being succeeded by Charles A. Ross, M.S., instructor in pharmacology at the University of Texas Medical Branch.

Woman's Auxiliary

KANAWHA

The regularly monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society was held Tuesday, November 14, at 8 P. M., at the home of Mrs. John E. Cannaday, in Charleston.

After a short business session conducted by Mrs. Ralph S. McLaughlin, the president, the evening was spent in playing bridge. The meeting was attended by twenty-two members and one guest.

MRS. JOHN W. HASH,
Secretary.

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MARION

A moving picture, "Here Is China," was shown at the regular monthly meeting of the Woman's Auxiliary to the Marion County Medical Society at the Fairmont Hotel, Fairmont, October 31.

At a short business session, Mrs. J. B. Clinton was named as chairman of the Children's Theatre Bureau, and Mrs. W. W. Orr and Mrs. J. E. Offner as representatives on the Community Council. The meeting was attended by 19 members, and Mrs. Orr, president of the Auxiliary, presided as chairman.

MRS. K. L. VAN HORN,
Secretary.

LICENSED BY EXAMINATION

The following doctors successfully passed the examination conducted by the Public Health Council at Charleston, October 2-4, 1944, and have been licensed to practice in West Virginia:

John Stephen Boling, Burke's Garden, Virginia; Harry Fred Cooper, Athens; Raphael Alan Fawcett, Wheeling; Bernard Mearns Hutchinson, Charleston; William Parks Jamison, Oakland, Maryland; Charles Lee Leonard, Beverly; Ward L. Oliver, Morgantown; Melvin Shein, Williamson; Hutton Blackman Strader, Elkins.

KANAWHA ENDORSES PROGRAM

Kanawha Medical Society with over 200 members, has indorsed in full the 1945 legislative program of the West Virginia State Medical Association. This action was taken at the regular monthly meeting at Charleston, November 21, and the vote was unanimous.

Book Reviews

VENTURES IN SCIENCE OF A COUNTRY SURGEON—Arthur E. Hertzler, M.D., Halstead, Kansas. With a Foreword by Raymond B. Allen, M.D., Dean of University of Illinois College of Medicine.

In the Preface of his latest book, Dr. Hertzler, the well known author of "The Horse and Buggy Doctor," states that even though he has practiced medicine for 50 years he will not admit that he is facing the setting sun, but that it is time to take an inventory. The reason he gives for writing "Ventures in Science of a Country Surgeon" is that he has seven granddaughters and grandsons, who are more or less headed for the medical profession.

Following a stimulating introduction, in which the author tells about his early boyhood, he describes his surgical researches in some detail, especially those on the peritoneum, wound healing and the thyroid gland. He insists, however, that,

"Only a few of the studies described in this book would ordinarily be classed as scientific study. In fact wound healing and the study of histochemistry of goiters can be classified as primarily scientific studies. Other problems which have engaged my attention were suggested by some clinical observation."

The latter third of the book deals with miscellaneous topics. Some of his chapter titles are interesting, if not even arresting: "Anxious Moments," "Trouble Sought For," "The Writing of Books," "Building a Library," "Visual Education," and "Adventures in Therapeutics."

The book is written in the true Hertzlerian manner. He does not pull his punches. He raps the American Medical Association, largely it seems, because the Council on Medical Education and Hospitals has not seen fit to recognize his hospital for the training of internes. Without a change of pace he goes after medical educators and puts them in their place and for good measure he takes up the cudgel against those responsible for premedical education.

Speaking of faculty meetings he writes:

"I found confirmation years later when out of curiosity I attended a faculty meeting . . . Obviously it was no place for one with a congenital sense of humor . . ."

This reviewer, who has had some experience in conducting medical school faculty meetings is quite ready to believe that Dr. Hertzler, if he were so minded, could well play the part of a bad boy in any faculty meeting.

Presumably he had premedical education in mind when he wrote:

"But colleges are interested not in making qualified pratitioners but in maintaining their dignity through the authority vested in them. The sooner the student medically bound discovers that he must get his education in spite of the faculty the better off he will be."

Those are fighting words and most college presidents and deans of liberal arts faculties probably would take violent exception and would want to commit mayhem, but it is to be hoped that their sense of humor would not desert them at such a critical time.

In speaking of examinations he writes:

"Though the rules required that written examinations be given, I have never been guilty of reading any of them . . . The examination was set for the afternoon of one fine day in May. I looked at the boys and they returned the gaze and it was obviously wistful. 'Meet you at the ball park' I said—presto, the seats were empty."

In spite of his jibes, however, at premedical and medical educators and their ways he pays high tribute to his former teachers: Fenger, Von Bergmann, Virchow, Waldeyer and others. Well he might, for these men were giants and any one of us would have been proud to have studied under them or indeed even to have known them.

This reviewer does not feel qualified to pass judgment on Dr. Hertzler's abilities as a surgeon nor on his contributions to surgery. It seems, however, that those who are in a position to judge, agree that he is an able pathologist and anatomist, a keen diagnostician and an outstanding surgeon. Throughout his book he places great emphasis on anatomy and pathology, both gross and microscopic. No doubt he is justified in laying emphasis on these important subjects, but it is the feeling of this reviewer that modern surgery is leaning more and more to the physiologic side rather than the pathologic.

There are many good laughs in Hertzler's book and one is tempted to give numerous examples to prove this point, but one will suffice:

"A hundred years ago some doctors discovered that iodide of potassium was good for the menstrual pains in young girls, that, and pushing a perambulator."

In several places his book contains delightful paradoxes, for instance, he contends that he is neither a surgeon nor a philosopher, but it seems that everyone will agree that he is a splendid surgeon and those who have read some of his recent books know that he is a philosopher.

The reader will not agree with everything Dr. Hertzler writes, but he is always stimulating. The young reader perhaps should be cautioned not to take him too seriously, because in straining for

effect Dr. Hertzler is apt to overshoot the mark. The book is printed on a good grade of paper and has a splendid format. It abounds in illustrations and, incidentally, one which interested this reviewer particularly is his "Laboratory of Experimental Surgery" (Size 10 by 12).

All in all, "Ventures in Science of a Country Surgeon" can be warmly recommended; it would make a nice little Christmas gift for any physician. —Edward J. Van Liere, M.D.

CONSERVING CHILDREN'S HEALTH

In the lives of probably the great majority of our children there is an interval of about four years between infancy and admission to school, which is usually a neglected period so far as proper medical attention is concerned. Nearly all babies, we know, receive some pediatric care during the first year of life, but when they begin to feed themselves and toddle around on their own feet, most parents take it for granted that as long as the children look well and do not complain too much they can get along well enough without medical supervision. Four or five years later, when they enter school, too frequently conditions come to light which have developed gradually during the preschool years, but which are now much more difficult to correct than would have been the case if discovered earlier. If we believe that an annual inspection by a school physician is worthwhile, how much more valuable should be a thorough examination periodically during the earlier years of formative development?—*Philadelphia Medicine.*

THE FAMILY DOCTOR

George Ade and Irvin Cobb, who for years lightened the world's cares with their humor and good cheer, wrote feelingly of the family doctor in answer to queries.

"Anything I have to say about the family doctor would be in his favor," wrote Ade. "For a great many years I have lived out in the country, far away from specialists. When anything ailed me, I called up the local practitioner, otherwise known as the family doctor, and I have always found him faithful, dependable, well informed, and sympathetic. His advice has always been good, even if I didn't always follow it. In recent years I have taken orders from him and lead a very quiet life, avoiding violent exercise and overindulgence in food, drink or excitement. Recently I have enjoyed reading some books written by country doctors and they have increased my respect for the general practitioner."

"I think the family doctor is a benefactor to the human race," declared Cobb, "and an idiot—although a noble and unselfish one—to follow so thankless a profession. My grandfather was a country doctor and a great one—and for one discovery, a famous doctor in his time. He was my ideal of what a physician—and a man—should be." —*Pennsylvania Medical Journal.*

OUR DOCTORS IN WAR

For the past many months our minds have been constantly occupied with thoughts of our members who are now on the battle-fronts. We have missed them sorely. Now that complete victory seems so much nearer, we are beginning to look forward to the day when they will return. Their brilliant achievements have won for them the admiration and good-will of all of the people at home. There is nothing we can do to restore them to a place in the hearts of the fathers and mothers of our fighting men. Their skill and their devotion to duty have made that place secure. But we can help to restore to them their old place in the practice of medicine. We can send back to them the patients who have come to us in their absence. We can see to it that no one takes advantage of their sacrifice. These things we solemnly pledge ourselves to do.—Jacob T. Oliphant, M.D., in *The J. of the Indiana St. Med. Assn.*

PSYCHIATRY IN BRITAIN

The following extract, dealing with the state of psychiatry in Britain, is taken from the report of the Interdepartmental Committee on Medical Schools: "Whether he is dealing with problems of health or sickness, the medical practitioner cannot fully understand his patients or advise and treat them adequately unless he pays due attention to their psychological background. The training in psychiatry has failed to keep pace with the growing realization of the important place which the subject should occupy in medical thought and practice. In future every medical teaching centre must have an adequate department of psychiatry, the work and teaching of which are related to the work and teaching of the other departments. These departments cannot be established until there is an adequate supply of competent teachers of psychiatry. The training of such teachers is a major and urgent need."—*The Canadian Doctor.*

UNIQUE CLUB FOR PATIENTS WHO HAVE LOST LARYNX

A unique club, composed of 100 men and women who have had their larynx, or speech organs, removed, has been organized at the National Hospital for Speech Disorders in New York, Dr. James Sonnett Greene, founder and medical director, announced.

The name of the club, Anamilo, which is Greek for "I speak again," tells the reason for the club's founding. A patient who has had his larynx removed must learn to speak again, either by using a mechanical device or artificial larynx, or by substituting an esophageal voice.

A special committee of the club has been formed to call, on the request of the attending surgeon, on patients in the metropolitan area who face larynx removal or have just had the operation. A visit from an Anamilo member is said to give much-needed reassurance to others about to have the larynx removed. Cancer is responsible for the loss of the larynx in most cases.—*Science News Letter.*

PSYCHOSOMATIC MEDICINE

The development of psychosomatic medicine, accompanied by the increasing tendency toward the establishment of psychiatric services in general hospitals, is doing much to break down the barriers between psychiatry and the other specialties of medicine which have existed. No longer is the psychiatrist looked upon as interested solely in the psychotic patient. He is becoming recognized as a useful colleague in the treatment of surgical and medical conditions. From the long range point of view, the development of psychosomatic medicine is the most significant psychiatric development of modern times.—Winfred Overholser, M.D., Sc. D., in *Virginia Medical Monthly.*

GERIATRICS AND NUTRITION

The branch of medicine called geriatrics has attracted serious attention only recently. It is defined as the specialty of diseases of old age. A related term—gerontology—that concerns the science of biologic, physiologic, and pathologic changes incident to old age has appeared lately and apparently has broader meaning. From medical, sociologic, and economic points of view geriatrics must become an important new field of investigation. As an illustration, the number of people in the age group of 65 and over will by 1950 equal the age

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group of those under 5. Accordingly, if these predictions are accepted as correct, there will be potentially as many old people who require specialized medical attention as young people.—*Nutritional Observatory.*

HAVE WE THE VISION,

The chief aim of the medical profession with the aid of government, church and philanthropy should be to build health assets—mental, moral and physical—because in the health of the people lies the strength of the nation.

We can trace the thread of scientific medicine from Hippocrates to the present time but along its length there are found very thin and fragile sections. In the last hundred years the science of medicine has swept down the valleys of ignorance, trial, and chance as a mighty torrent, adding decades to our life's span through prevention and cure.

England, Germany, France and Italy were the meccas for medical education for many years, but when politics took hold of them and gave them

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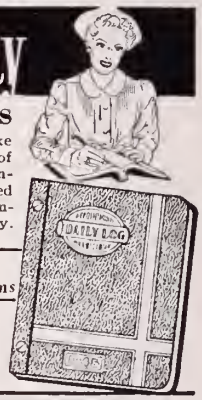

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socialized medicine in a large measure their light began to fail. In the immediate future and for many years to come, the United States will be the world center for medical education. We must not only hold and continue to improve standards, but we must practice the good neighbor policy of sharing with the world our democratic medicine.—*The Mississippi Doctor.*

THE PHYSICIAN AND HEALTH

To the individual physician any proposed changes in our social system should be full of meaning, for in the effort to maintain the independence and ideals of our profession it is he who is the unit of force. What the public thinks of medicine finally rests in what they think of him. His duty becomes then something much more than the professional care of the sick. Society looks to him for leadership in all of its affairs having to do with health. This idea of conduct was expressed nearly a century ago by a Connecticut physician, William Andrus Alcott, in these prophetic words, "A physician must be essentially a missionary of health. —*Conn. St. Med. J.*

BORDEN AWARD

"For outstanding achievement in research in nutrition of infants and children," Dr. Harry Gordon, assistant professor of Pediatrics and Dr. S. Z. Levine, professor of Pediatrics, at the Cornell University Medical College were joint recipients of the first annual Borden Award to be administered by the American Academy of Pediatrics. Presented at the Academy's Wartime Conference on Child Health in St. Louis, Missouri, the award was made for metabolic studies on the nutritional requirements of premature and full-term infants. These studies contribute a physiologic basis for individualized feeding.

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Communications

To the Editor of
The West Virginia Medical Journal:

Adoption of the Unwanted Baby

A social agency is always ready to come to the help of the mother with an unwanted child. The physician is usually the first person outside of the family to be consulted by the mother. The social agency would like to be in touch with the clandestine expectant mother as soon as possible so that some plan for the expected child can be worked out, in confidence, of course.

The unmarried mother faces the question of what shall be done when the baby arrives. It is a tremendous problem which involves not only the child's future but will be vital to her own prospects of marriage and a happy home. Sympathetic and capable advice can help her to see what may be expected if she is to keep her child, or if she is to surrender it for others to adopt.

After the facts have been faced and the decision is made to adopt the child, the experienced agency (which is licensed to place children for adoption) will handle the case in accordance with the law. and assume responsibility for the action taken. There are many legal and social problems which may arise between the time the mother signs the release and the six months demanded by law before the adoption can be completed. The placing agency is responsible for the success of the placement, the adjustment of the child to the home, and the completion of the adoption.

It is the writer's impression that many such placements are made by the physician, who has a desire to help the mother out of her difficulty and at the same time get a baby for some lonely couple who have applied to him. This communication is intended to let that physician know that these services are available, without charge to the mother, by an experienced case worker.

West Virginia has three licensed child-placing agencies, as follows: The Children & Family Association, Wheeling; The Union Mission, Charleston; and the Childrens Home Society of West Virginia, Charleston, widely known by its receiving home, the Davis Child Shelter. In addition, the state department of public assistance is able to accept guardianship for children for adoption. They work through their county departments.

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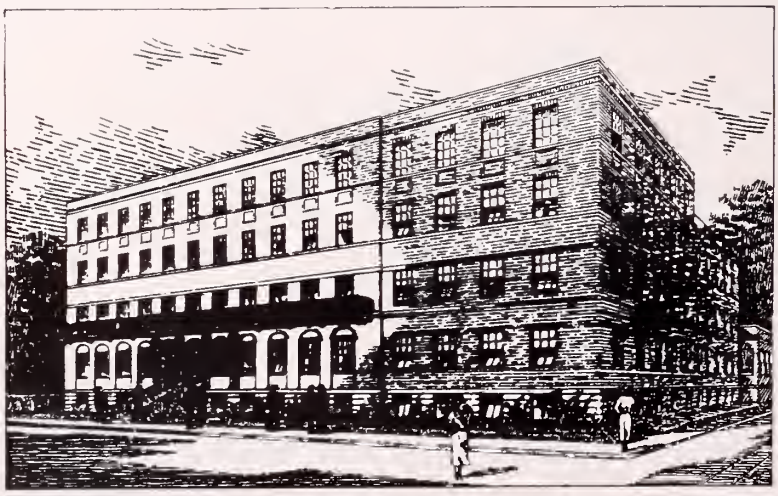

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Whether a case be referred to us early or late, the physician may be assured that the child will not be neglected if it is within the borders of West Virginia.

Very respectfully,

RONALD S. CLELAND, *Supt.*

Childrens Home Society of West Virginia.

TWO CAMPS

All this talk about the white-paper shows, I think, that the profession is divided into two camps, with saints and sinners in both. In the first camp are the good doctors to whom freedom means what it means to the creative artist; these must do their work in their own way without outside interference of any sort. Also in this camp are the shopkeepers, who consiciously or otherwise regard medicine as a business; you can always spot these at meetings because, despite protestations to the contrary, they view all proposed changes solely in the light of how their pockets will be effected.

In the second camps are the good doctors who simply can't be bothered about money at all, and who want to get on with the job because they think it a job worth doing; these are better off working for a salary—they are apt to go hungry otherwise; because they constantly forget to collect their just dues. There are also bad doctors in this camp who want sinecures; these are the safe men whose sole idea is to get through life with a minimum of troubles and effort. It looks as though the two camps can never be reconciled; but how nice it would be if we could purge the duds for both.—Peripatetic Correspondent in *The Lancet* as quoted in *Canadian Doctor.*

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PREVENTIVE FOR AIRSICKNESS

Airsickness among a large group of cadets in training at the Naval Training Center, Pensacola, Florida, was almost completely banished by giving them pills containing hyoscine one-half to one hour before the take-off, Lt. Joseph L. Lilienthal reported to the meeting of the Aero Medical Association, according to *Science Service*.

Hyoscine has long been credited with ability to prevent and cure seasickness. Under its other name of scopolamine, it was familiar some years ago as one of the drugs used to induce twilight sleep anesthesia for childbirth.—*Science Digest*.

SOAP AND INFLUENZA

Soaps seem to destroy the infectivity of influenza virus. Of great practical significance is the protection against virus infection afforded by the use of soap in the cleansing of soiled surfaces.

To reduce the danger of influenza a careful toilet of the skin of face and hands and toilet of the mucous membrances of the nose and throat, after exposure, especially during actual epidemics, should be given prime consideration. Agents are available for these purposes by which the activity of the viruses may be greatly diminished. In this way one may assure a degree of protection for himself and also, of no less consequence, protection for his intimate associates.—*Ward J. MacNeal and Ernestine R. Parker in Am. J. Clin. Path.*

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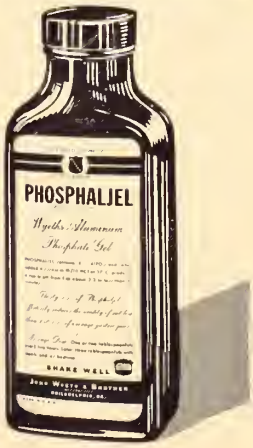

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